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# ELIMINATING PATIENT DUMPING: A PROPOSAL FOR MODEL LEGISLATION

## I. INTRODUCTION

*It would shock the public conscience if a person in need of medical emergency aid would be turned down at the door of a hospital having emergency service because that person could not at that moment assure payment for the services. The public expects such service.<sup>1</sup>*

As health care costs rise and the number of uninsured Americans increases, the phenomenon known as patient dumping<sup>2</sup> has become a problem of large

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1. Mercy Medical Ctr. of Oshkosh v. Winnebago County, 206 N.W.2d 198, 201 (Wis. 1973).

2. Patient dumping is defined as "the denial of emergency medical services or the premature transfer of a patient from one hospital to another because the person cannot guarantee payment." Geraldine Dallek & Judith Waxman, *Patient Dumping: A Crisis in Emergency Medical Care for the Indigent*, 19 CLEARINGHOUSE REV. 1413 (1986).

There is also a problem known as reverse patient dumping, which occurs when a hospital with improper resources attempts to transfer a patient to a larger, better equipped hospital, and the hospital refuses to accept the transfer of the patient. SUBCOMM. ON HUMAN RESOURCES & INTERGOVERNMENTAL RELATIONS TO HOUSE COMM. ON GOVT. OPERATIONS, EQUAL ACCESS TO HEALTH CARE: PATIENT DUMPING, H.R. REP. NO. 531, 100th Cong., 2d Sess. 18 (1988) [hereinafter EQUAL ACCESS].

An example of reverse patient dumping was at issue in a Texas case where a small hospital attempted to transfer a seventeen year old boy with a bullet lodged in his brain to a larger tertiary care hospital. The larger hospital refused the transfer because they had a blanket policy that uninsured or Medicaid patients would not be accepted by transfer. The boy's parents took him to the larger hospital, and upon arrival the duty on the part of the hospital to render emergency care arose under the Emergency Medical Treatment and Women in Active Labor Act (EMTALA). But eight hours had passed and the boy died. *Id.* For a discussion of EMTALA, see *infra* notes 74-194 and accompanying text.

"Body Snatching" is another variation on the idea that patients are being treated and transferred to hospitals based on their ability to pay for the services. When body snatching occurs, a patient with insurance or the ability to pay for medical services is transferred from a public hospital to a private hospital. Joe Calderone & Kevin McCoy, *Hospital Hit for "Body Snatching,"* NEWSDAY, Dec. 16, 1991, at 5. Some experts have stated that "self dumping" also occurs in hospitals. Self dumping means that patients have found that it is worthless to go to the private hospital where they know they will not be given care without medical insurance, so the patients go directly to the public hospitals. Interview, *Public Hospitals: Health Care's Safety Net*, HOSPITALS, March 20, 1989, at 76-77.

An example of the public's perception that hospitals dump patients without medical insurance is the case of Mr. Milligan. Mr. Milligan was on vacation with his friend Mr. McElveen when McElveen fell down a rocky waterfall. McElveen had no health insurance, so when Milligan took him to the hospital Milligan represented McElveen as himself. Milligan's insurance company paid \$41,107.45 in medical bills for McElveen, but later found out that Milligan committed fraud.

proportion.<sup>3</sup> It is estimated that thirty-six million Americans, fifteen percent of the population, have no health insurance.<sup>4</sup> The total annual cost of health care for uninsured Americans is \$9.7 billion.<sup>5</sup> These health care costs have led hospitals to refuse to care for or dump patients who lack health insurance or are indigent<sup>6</sup> and unable to pay for the medical services.<sup>7</sup> Approximately 250,000

McElveen and Milligan were both convicted of health care fraud. Milligan was sentenced to nine months in prison; McElveen was sentenced to seven months in prison.

Milligan claimed he misrepresented his insurance coverage because he feared that if payments were not guaranteed, doctors would refuse to treat his friend without health insurance. Milligan's friends had told him that the Tennessee hospitals were notorious for dumping uninsured patients. Randy McClain, *ID Swap For Back Operation Lands 2 Men in Prison; Man Says Friend's Lack of Insurance Prompted Him To Lie After the Accident*, THE DALLAS MORNING NEWS, February 14, 1993, at 47A.

For a general overview of patient dumping, see 104 A.L.R. FED. 166 (1992).

3. In a survey of health care chief executive officers, 13% of the officers found that patient dumping occurred in hospitals in their geographic areas. Karen Pollarito, *Patient Dumping Occurring, Say 13% of CEO's*, MOD. HEALTHCARE, June 22, 1992, at 24.

As the House Report on patient dumping stated:

Hospitals have been financially squeezed by cross currents of Medicaid payment reductions, Medicare payment changes and growing numbers of uninsured patients. As economic constrictions increase and hospital administrators are forced to act like businessmen concerned mainly with profits, more and more patients will lose access to desperately needed care simply because they cannot pay. Many hospitals have forsaken their earlier commitment to patient access to health care for one of cost containment and restraint.

EQUAL ACCESS, *supra* note 2, at 7.

4. Joanne S. Morrissey, *Fair Coverage for All; Health Insurance Prescription*, BEST'S REVIEW, LIFE-HEALTH INSURANCE EDITION, Nov. 1992, at 57.

5. *Id.* Furthermore, 57% of Americans have health insurance through their employer, 12% are covered by Medicare, 7% by Medicaid, and 8% have other private coverage.

The total spending on healthcare in 1992 was \$838.5 billion, more than 14% of the nation's total economic production. Eric Weissenstein, *Health Spending Hits \$838 Billion in 1992*, MOD. HEALTHCARE, Jan. 11, 1993, at 2. Additionally, hospital expenditures alone amounted to \$323.2 billion in 1992. It is estimated that in 1993 this amount will rise to \$363 billion. *Id.*

6. Indigency is defined as "one who is needy and poor or one who has not sufficient property to furnish him a living nor anyone able to support him to whom he is entitled to look for support." BLACK'S LAW DICTIONARY 773 (6th ed. 1990).

In addition, people who are considered medically indigent include:

Those who by definition lack adequate health insurance, poor people who have no public insurance, substantial numbers of unemployed or self employed persons who are uninsured, many employees of small businesses that do not provide health care benefits, elderly people eligible for Medicare but requiring extended-care facilities and services, and patients in high-risk medical categories who are uninsurable.

Donald O. Nutter, *Medical Indigency and the Public Health Care Crisis, The Need for a Definitive Solution*, 316 NEW ENG. J. MED. 1156, 1156 (1987).

7. A study of Cook County hospitals that transferred patients from their emergency departments showed that 87% of the patients were transferred because they lacked health insurance. Robert L. Schiff, et al., *Transfers to a Public Hospital, A Prospective Study of 467 Patients*, 314 NEW ENG. J. MED. 552, 555 (1986). The study also showed a dramatic increase in the number of interhospital transfers. One Cook County Hospital showed increases from 1295 in 1980, to 2906 in 1981, 4368

patients are dumped each year.<sup>8</sup> Most patient dumping takes place from hospital emergency rooms.<sup>9</sup>

Consider the case of an uninsured pregnant woman who was in labor and went to a private hospital.<sup>10</sup> The hospital kept the woman in a wheelchair in the lobby for two hours and fifteen minutes.<sup>11</sup> Hospital administrators checked the woman once, but performed no tests on the fetus.<sup>12</sup> The hospital administrator then informed the woman that she must go to the nearest county hospital.<sup>13</sup> At the county hospital the woman gave birth to a stillborn child.<sup>14</sup>

The case of *Chandler v. Hospital Authority of the City of Huntsville*<sup>15</sup> also illustrates the patient dumping problem. In *Chandler*, a mother took her fifteen-month-old child to the hospital, and the hospital refused to render treatment unless the mother had medical insurance or a fifty-four dollar fee.<sup>16</sup> The mother was told to take the child home and give the child Tylenol and a warm bath.<sup>17</sup> The child died the next day from spinal meningitis.<sup>18</sup> Hospitals, in many cases, refuse to render treatment to patients because the hospitals fear that

in 1982, and 6769 in 1983. *Id.* at 552.

Additionally, the study found that the average treatment delay of 5.1 hours adversely affected patients with certain conditions. *Id.* at 556.

8. David A. Ansell & Robert L. Schiff, *Patient Dumping: Status, Implications and Policy Recommendations*, 257 J.A.M.A. 1500 (1987).

9. EQUAL ACCESS, *supra* note 2, at 2. In addition, the House Report indicated that many patients may be transferred based on discrimination. *Id.* A recent study of patient transfers to a Cook County hospital from other hospital emergency rooms showed that 89% of the transferred patients were black or Hispanic. Schiff, *supra* note 7, at 552.

Patients who are discriminated against in receiving medical care may have a cause of action for patient dumping under the Rehabilitation Act of 1973, 29 U.S.C. § 794 (1973), or under the Civil Rights Act, 42 U.S.C. § 1983 (1988).

10. EQUAL ACCESS, *supra* note 2, at 6. The House Report also discussed a case that involved a diabetic who was suffering from acute ketoacidosis and was taken to a hospital for emergency treatment. After the hospital admitted the patient, the hospital administrator lifted the patient out of bed, walked him to the hospital parking lot, and left him there without a shirt or shoes. The patient was uninsured and already owed the hospital money. The next day the patient died. An investigation pursuant to EMTALA found no violation of the federal patient dumping statute. *Id.* at 6.

11. *Id.*

12. *Id.*

13. *Id.*

14. *Id.*

15. 548 So.2d 1384 (Ala. 1989).

16. *Id.* The court denied a motion for summary judgment.

17. *Id.* This action by the hospital triggered the common law duty to act although no legal duty to act existed before such action.

18. *Id.*

the patients will be unable to pay the medical bill.<sup>19</sup>

Historically, a hospital could refuse to treat any patient without explanation because there was no legal duty to render care.<sup>20</sup> Courts slowly eroded this common law no duty rule by holding that if a patient relied on a custom of the hospital to render aid, there was an implied duty on the hospital's part to care for the patient.<sup>21</sup> Additionally, if a hospital began to render care, it could be held liable if it failed to continue the care, even though no legal duty to act existed before the voluntary act.<sup>22</sup>

The first federal response to the patient dumping problem, the Hill-Burton Act,<sup>23</sup> was passed in 1946. The most recent federal attempt to regulate patient dumping, the Emergency Medical Treatment and Women in Active Labor Act (EMTALA),<sup>24</sup> was passed in 1986. The existing federal patient dumping laws have not effectively monitored or enforced the provisions requiring medical facilities to provide emergency medical care.<sup>25</sup> State legislatures also have responded to the patient dumping problem by enacting statutory regulations

19. This fear is rational on the hospital's part given that indigent patients have no ready means to pay the bills, and no insurance company will cover the costs.

A recent survey of the American Hospital Association records showed: 1) the amount of free care rendered by hospitals in dollar amounts rose from approximately 36% in 1986 to 64% in 1990; 2) in 1990 hospitals lost 6% of their overall gross patient revenues to uncompensated care charges. David Burda, *Charity Care: Are Hospitals Giving Their Fair Share?; Misleading Data, Disparities In Definitions Muddy The Debate Over How Much Charity Care Is Provided And How Much Is Enough*, MOD. HEALTHCARE, June 15, 1992, at 22.

20. *Chandler v. Hospital Auth. of Huntsville*, 548 So.2d 1384 (Ala. 1989) (holding that although a hospital has no affirmative duty to treat patients in emergency conditions, once a hospital begins to render assistance it is liable to provide care); *Harper v. Baptist Medical Ctr.-Princeton*, 341 So.2d 133, 134 (Ala. 1976) (holding that the hospital owed no duty of care to a person who has not already been accepted as a patient); *Citizens Hosp. Ass'n v. Schoulin*, 262 So.2d 303 (Ala. App. 1972) (finding that a hospital has no duty to treat a patient it finds to be unacceptable).

21. *See, e.g., Wilmington Gen. Hosp. v. Manlove*, 174 A.2d 135, 140 (Del. 1961). Courts found this implied duty based on the fact that if a person relied on the hospital's custom of providing care their condition may be worsened in the futile attempt to obtain care at the hospital. *Id.* at 138.

22. *Johnson v. University of Chicago Hosp.*, 982 F.2d 230, 232 (7th Cir. 1992) (holding that under Illinois law a hospital telemetry system operator who voluntarily assumed responsibilities could be held liable if such duties were performed negligently). The case was remanded for further findings of fact. *Id.*

23. *The Public Health Service Construction and Modernization of Hospitals and Other Medical Facilities Grants and Loans for Construction and Modernization of Hospital and Other Medical Facilities*, 42 U.S.C.S. § 291 (West Supp. 1992).

24. *The Emergency Medical Treatment and Women in Active Labor Act*, 42 U.S.C.A. § 1395dd (West Supp. 1992).

25. *See infra* notes 70-73 and accompanying text for a discussion of the Hill-Burton Act; *see infra* notes 160-70 and accompanying text for a discussion of EMTALA.

requiring medical facilities to render emergency care.<sup>26</sup> The main problems with the state enactments are the lack of clear definitions of essential terms and the absence of a specific remedy under state law.<sup>27</sup>

Hospitals render \$300 million in uncompensated medical care each year.<sup>28</sup> The legal response to patient dumping must provide all Americans with emergency health care.<sup>29</sup> Such care must be rendered without driving hospitals out of business, because such an effect would result in less emergency care being available.<sup>30</sup> Regulations on patient dumping must strike a balance between the necessity of emergency medical care and the cost containment

26. Approximately 21 states have enacted legislation to prohibit patient dumping. See *infra* note 207 and accompanying text for a discussion of the state statutes.

27. See *infra* notes 207-33 and accompanying text. See also Karen I. Treiger, *Preventing Patient Dumping: Sharpening the Cobra's Fangs*, 61 N.Y.U. L. REV. 1186, 1202 (1989) (concluding that state statutes are weak and lack definitions of emergency services, adequate remedies, and enforcement procedures).

28. H.R. REP. NO. 241, 99th Cong., 1st Sess., pt. 3, at 5 (1986), reprinted in 42 U.S.C.C.A.N. 748. Emergency physicians are a medical speciality and 15,000 emergency room physicians treat more than 77 million emergency patients each year. *Id.* at 741.

29. The House report stated:

Inappropriate and unlawful transfers of patients from one hospital to another often have tragic consequences. They cause unnecessary suffering- physical and mental anguish, humiliation, and loss of life and limb. In some instances, babies have died who would have lived had medical treatment not been delayed because of a transfer. Access to adequate health care is a basic necessity of life that should be available to every American regardless of their economic status.

EQUAL ACCESS, *supra* note 2, at 20.

30. Critics of patient dumping legislation allege that the ultimate result of such legislation will be a net reduction in the emergency care available to the indigent because such statutes cause emergency room closures. Mark A. Hall, *The Unlikely Case in Favor of Patient Dumping*, 28 JURIMETRICS J. 389, 394 (1988). Critics further allege that if patient dumping laws are successful at all it is only to the point of postponing the dumping of patients to the point in time when the patients are stabilized. The patient dumping laws do not require all emergency treatments, only those that are necessary to stabilize, and this only touches the surface of the problem. *Id.* at 393.

The recent case of *Powers v. Arlington Hosp.*, 800 F. Supp. 1384 (E.D. Va. 1992), illustrates the problem of patient dumping fines being so high that hospitals may be forced to close their doors. In *Powers*, the plaintiff was discharged from the emergency room of Arlington Hospital after a two hour examination. The hospital discovered that the plaintiff was uninsured and unemployed. The hospital ordered tests, but discharged the plaintiff before the results were reported. The plaintiff returned to the hospital the next day, and it was determined that she was suffering from septic shock. The plaintiff was hospitalized for four months, had both of her legs amputated and lost the sight in her eyes. *Id.*

The plaintiff filed both a malpractice claim and a claim under EMTALA for patient dumping. Virginia has a one million dollar cap on malpractice damages. *Powers* was able to collect four million dollars in damages under her patient dumping claim. *Id.*

These types of damages encourage plaintiffs to use the patient dumping statute as a method of recovering more monetary damages than they can collect under a malpractice claim, instead of deterring patient dumping which is the purpose of the law. Further, such high damage awards will result in the closure of hospitals and ultimately a lower availability of medical care.

problems that medical facilities face.<sup>31</sup>

This Note examines both the federal response to the patient dumping problem and state attempts to solve the problem through case law and statutory enactments. More specifically, Section II of this Note discusses the federal response to patient dumping implemented by the Hill-Burton Act and EMTALA. Section II discusses the federal laws' failure to prevent patient dumping. Next, Section III analyzes the judicial interpretations of EMTALA. Section III also focuses on legal issues that are unclear from EMTALA's plain language and the inconsistent approach that the courts have taken in filling in the gaps of EMTALA's language.

Furthermore, Section IV discusses the interaction between the federal patient dumping laws and state medical malpractice laws. Section IV emphasizes that a claim for personal harm damages under patient dumping should not create a national medical malpractice cause of action. Next, Section V discusses the state regulations on patient dumping. The analysis of the state regulations on patient dumping includes statutory enactments and a discussion of common law cases. Finally, Section VI concludes this Note by proposing model legislation for Indiana to adopt to attack the patient dumping problem. The proposed legislation defines specific terms and directly addresses the conflict between the federal patient dumping laws and state medical malpractice claims.

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31. "True cost containment depends on controlling the costs of the health care system as a whole, without impairing quality." Eli Ginzberg, *A Hard Look at Cost Containment*, 316 NEW ENG. J. MED. 1151, 1152 (1987). Critics of cost containment argue that such provisions lead to fewer medical services, and that people will correctly perceive medical services to be declining in quality. Victor R. Fuchs, *The Counterrevolution in Health Care Financing*, 316 NEW ENG. J. MED. 1154, 1155 (1987).

Some health care experts say that cost containment problems in health care have arisen because of new medical technology and the increase of the United States population. In particular, the elderly population has increased and therefore health care costs have also increased. Kenneth A. Kovach, *Health Care Cost Containment: An Impossible Dream?* 42 LAB. L.J. 660, 661 (1991).

Some hospitals admit that cost shifting will continue to occur, "When you buy a shirt, you pay for all the shirts that have been shoplifted. Similarly, when you get a broken arm treated, you pay for the treatment of all uninsured patients' broken arms." Carolyn Hirschman, *Charity Care Burdens Hospitals*, BUSINESS FIRST-COLUMBUS, August 19, 1991, at 1.

## II. THE FEDERAL RESPONSE TO PATIENT DUMPING

### A. *The Hill-Burton Act*

In 1946 Congress passed the Hill-Burton Act.<sup>32</sup> The Hill-Burton Act was passed in part as a response to President Truman's message to Congress, which called for financial barriers to be removed from the attainment of health care.<sup>33</sup> One of the Hill-Burton Act's primary goals was to provide a reasonable amount of free or reduced cost medical care for the indigent.<sup>34</sup> Under the Hill-Burton

32. Hospital Survey and Construction (Hill-Burton Act), 42 U.S.C.S. § 291 (West Supp. 1992). The Hill-Burton Act states, in relevant part:

The State shall provide for adequate hospitals, and other facilities for which aid under this statute is available, for all persons residing in the State, and adequate hospitals (and other such facilities) to furnish needed services for persons unable to pay therefor. Such regulations may also require that before approval of an application for a project is recommended by a State agency to the Surgeon General for approval under this part, assurance shall be received by the State from the applicant that: 1) the facility or portion thereof to be constructed or modernized will be made available to all persons residing in the territorial area of the applicant; and 2) there will be made available in the facility or portion thereof to be constructed or modernized a reasonable volume of services to persons unable to pay thereof, but an exception shall be made if such a requirement is not feasible from a financial viewpoint.

*Id.*

33. President Truman's Message to Congress on Health Legislation, 1945 U.S.C.C.A.N. 1143. President Truman stated, "Millions of our citizens do not now have a full measure of opportunity to achieve and enjoy good health. Millions do not now have protection or security against the economic effects of sickness. The time has arrived for action to help them attain that opportunity and that protection." *Id.*

34. *Hearings Before the Comm. on Educ. and Labor on S. 191*, U.S. Senate, 79th Congress, 1st Sess., March 12, 1945, at pp. 190-91. Senator Ellender indicated that a primary reason for supporting a federal bill that gives aid to hospitals was to allow the hospitals to aid indigents in need of health care. *Id.*

Another legislative goal of the Hill-Burton Act was to increase the amount of medical facilities and to improve already existing facilities. H.R. REP. NO. 2519, 79th Cong., 1st Sess. (1946), reprinted in 1946 U.S.C.C.A.N. 1558. The bill stated:

Basic Purpose:

1. To help the States survey all existing hospitals and public health centers and determine their adequacy, to afford the facilities necessary for adequate service to all the people of the State, and plan State-wide construction programs of the facilities needed, in conjunction with the existing facilities, to supply such service, and,
2. To assist in the construction of needed facilities for public and other nonprofit hospitals and for public health centers which are in conformity with the approved State construction program and the standards for construction projects required under this bill.

*Id.*

While this indicates concern for the physical premises of medical facilities, the legislature's concern was also directed to the provision of health care to the indigent. The Senate report stated:

It is not uncommon for hospitals to close departments or phase out services which are in and of themselves unprofitable, even though the facility's overall financial health

Act, medical facilities<sup>35</sup> receive federal funds for construction<sup>36</sup> or modernization<sup>37</sup> of their facilities. In exchange, medical facilities must provide free or reduced medical care for the indigent.<sup>38</sup> From 1947 to 1974, \$4.4 billion in Hill-Burton funds were appropriated to medical facilities.<sup>39</sup> In the last thirteen years, more than \$2.5 billion in charity medical care have been provided by hospitals that received Hill-Burton funds.<sup>40</sup>

A medical facility that receives Hill-Burton funding is presumed to be in compliance with the Act if it provides: 1) uncompensated health care in the amount of at least three percent of the overall operating costs of the medical facility, or ten percent of the amount of the federal funds the facility has received under the Hill-Burton Act,<sup>41</sup> or 2) the facility certifies that it will not exclude any person from admission to its facility based on the person's inability to pay for the services, and that it will provide care for patients at a reasonable cost.<sup>42</sup> In addition, all facilities that receive Hill-Burton funds must make the facility or the portion of the facility that is being constructed or modernized

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may be sound. These closures or phaseouts can be particularly devastating to the poor if, as is often the case, the clinics or departments involved are the source of scarce emergency room or outpatient services.

S. REP. NO. 96, 96th Cong., 1st Sess. (1979), *reprinted in* 1979 U.S.C.C.A.N. 1306, 1396. The report further stated, "The committee intends that the guidelines for the disbursement of the incentive payments should assure that the facilities and clinics on which the poor and minorities rely for inpatient and outpatient care are not discontinued." *Id.*

35. The term "medical facilities" includes hospitals, laboratories, outpatient departments, nursing home facilities, extended care facilities, self-care units, education or training facilities for medical personnel, public health centers, and rehabilitation facilities. 42 U.S.C.S. § 291o(4)(c)-(g) (1992).

36. The term "construction" incorporates "construction of new buildings, expansion, remodeling, and alteration of existing buildings, and initial equipment of such buildings including architect fees." *Id.* § 291o(4)(i).

37. The term "modernization" incorporates, "alteration, major repair, remodeling, replacement, renovation of existing buildings (including initial equipment thereof), and replacement of obsolete, built-in equipment of existing buildings." *Id.* § 291o(4)(k).

38. 42 C.F.R. § 53.111(d) (1992). These requirements for compliance are commonly known as, "the community service assurance and the reasonable volume of uncompensated care assurance." *American Hosp. Ass'n v. Sweiker*, 721 F.2d 170, 172 (7th Cir. 1983).

39. S. REP. NO. 1285, 93d Cong., 2d Sess. (1974), *reprinted in* 1974 U.S.C.C.A.N. 7860. The following appropriations (in millions of dollars) were made to medical facilities under the Hill-Burton Act: 1948- \$75.0, 1949- \$75.0, 1959- \$150.0, 1951- \$85.0, 1952- \$82.5, 1953- \$75.0, 1954- \$65.0, 1955- \$96.0, 1956- \$109.8, 1957- \$123.8, 1958- \$120.0, 1959- \$185.0, 1960- \$185.0, 1961- \$185.0, 1962- \$209.7, 1963- \$220.0, 1964- \$220.0, 1965- \$220.0, 1966- \$258.5, 1967- \$270.0, 1968- \$267.2, 1969- \$267.2, 1970- \$172.2, 1971- \$172.7, 1972- \$197.2, 1973- \$197.2, 1974- \$197.2. *Id.* at 7861.

40. Burda, *supra* note 19, at 22.

41. 42 U.S.C.S. § 291c(e)(1) (West Supp. 1992); 42 C.F.R. 53.111(d)(1) (West Supp. 1992).

42. 42 U.S.C.S. § 291c(e)(2) (West Supp. 1992); 42 C.F.R. § 53.111(d)(2) (West Supp. 1992).

available to all people in the immediate area.<sup>43</sup>

These requirements for providing care only apply to medical facilities that receive federal Hill-Burton funds.<sup>44</sup> Furthermore, even facilities that receive federal funds are not required to provide services from their entire facilities.<sup>45</sup> The medical facilities are only required to provide services that constitute a reasonable volume<sup>46</sup> of medical care in light of the amount of federal funds they have received, and given the nature of their particular community needs.<sup>47</sup> Medical facilities that receive Hill-Burton funds must render the required aid to the indigent for twenty years.<sup>48</sup>

The Hill-Burton Act requires facilities that receive federal funds for construction or modernization of the medical facilities to post a notice of their obligation to provide care to the indigent.<sup>49</sup> The notice must be posted in the admissions office, the emergency department, and the business office.<sup>50</sup> In addition, the facilities must post the dollar limit in uncompensated services they must provide under the Hill-Burton Act and the volume of such services that have already been provided.<sup>51</sup>

One early recognized flaw of the Hill-Burton Act was that the requirement that a medical facility provide free services to the indigent was not actually enforced from 1946, when the statute was enacted, until 1972, when the first enforcement procedures were created.<sup>52</sup> The enforcement procedures consist

43. 42 U.S.C.S. § 291(c)(e)(1) (West Supp. 1992).

44. *Gordon v. Forsyth County Hosp. Auth.*, 409 F. Supp. 708, 721 (M.D.N.C. 1976), *aff'd in part and vacated on other grounds*, 544 F.2d 748 (4th Cir. 1976).

45. *Id.*

46. A reasonable volume of medical care is defined as, "a level of uncompensated services which meets a need for such services in the area served by an applicant and which is within the financial ability of such applicant to provide." 42 C.F.R. 53.111(b)(7) (West Supp. 1992).

47. *Gordon*, 409 F. Supp. 708, 720 (M.D.N.C. 1976). The court found that if all aspects of a medical complex that received federal funds under the Hill-Burton Act were required to render free health care to the indigent, the result would be an unjustified and undue burden on the medical facility receiving the federal funding. *Id.*

48. 42 C.F.R. 53.111(a) (West Supp. 1992).

49. *Id.* at 53.111(i). The notice states, "This hospital (or other facility) is required by law to give a reasonable amount of service at no cost or less than full cost to people who cannot pay. If you think that you are eligible for these services, please contact our business office (give office location) and ask for assistance. If you are not satisfied with the results, you may contact (the State Hill-Burton agency with address)."

50. *Id.*

51. *Id.*

52. *Newsom v. Vanderbilt Univ.*, 453 F. Supp. 401, 409 (M.D. Tenn. 1978), *aff'd in part and modified in part, rev'd in part*, 653 F.2d 1100 (6th Cir. 1981). Further, the enforcement regulations were enacted as a result of private lawsuits that were brought, not any independent actions of the legislature or administrative agencies. *Id.* The lack of enforcement procedures for this twenty-five

of state agencies evaluating and enforcing vague provisions established by the Department of Health and Human Services.<sup>53</sup> The enforcement provisions require facilities that apply for Hill-Burton funds to submit an assurance that they will comply with the community service requirements of the Act.<sup>54</sup> The state agency reviews these assurances before they approve an application for Hill-Burton funds.<sup>55</sup> The state agency then annually evaluates compliance with the assurance by the facility.<sup>56</sup> In addition, the state agency is required to set procedures to deal with complaints alleging that the facility has not met its obligations.<sup>57</sup> The enforcement provisions suggested included license revocation, termination of state assistance, and court actions.<sup>58</sup> Moreover, the enforcement provisions were created as a response to private lawsuits alleging that facilities were not complying with the Hill-Burton requirements.<sup>59</sup>

These enforcement provisions leave the specific methods of enforcement to the individual state agencies that are established.<sup>60</sup> The Department of Health and Human Services is involved to the extent that it approves a state plan, and it receives state reports of legal action involved when a medical facility does not comply with the community service assurance.<sup>61</sup> The failure of these enforcement provisions to state in the statute what steps will be taken if compliance is not met is an essential flaw in the attempt to deter facilities from

year period caused problems for courts in determining when the period of regulated activity and free medical care is measured. Prior to the enactment of the 1972 enforcement procedures, medical facilities were not on notice of the threatened enforcements which would be rendered against them if they violated their duty to provide health care to the indigent in exchange for federal Hill-Burton funds. Practical considerations also became an issue because prior to 1972 there was no requirement that records be kept of the free Hill-Burton health care provided. *Id.* at 410.

53. 42 C.F.R. § 53.111 (West Supp. 1992).

54. *Id.* § 53.111(c)(1) (West Supp. 1992).

55. *Id.*

56. *Id.*

57. *Id.*

58. *Id.* § 53.111(2) (West Supp. 1992).

59. *Id.* § 53.113(f) (West Supp. 1992). Critics of administrative agencies allege that Congress delegates authority on issues to administrative agencies with vague statutory standards. The agencies then become vulnerable to the pressures exerted by the private groups the legislation sought to control. James O. Freedman, *Crisis & Legitimacy in the Administrative Process*, 27 STAN. L. REV. 1041, 1054-1055 (1975).

See also Rande E. Rosenblatt, *Health Care Reform and Administrative Law: A Structural Approach*, 88 YALE L.J. 243, 250 (1978) ("The task of developing an operational program of financial inducement and regulatory control is then delegated with little legislative guidance to federal and state agencies, where the crucial policy and enforcement decisions have much less public visibility than the original legislation. At the administrative stage, organized provider interests are better than unorganized consumers to extract tangible benefits and to shape the programs to their own ends.").

60. 42 C.F.R. § 53.111(1) (West Supp. 1992).

61. *Id.*

refusing to render the required care. If a facility is not aware of the ramifications of noncompliance at the time it accepts the Hill-Burton funds, it is not likely to be deterred from refusing care based on those penalties. The lack of enforcement of the Hill-Burton Act has led to a failure of Congress' goal in providing adequate health care to the indigent.<sup>62</sup>

Another problem with the Hill-Burton Act is that the only remedy an indigent plaintiff has, if a medical facility fails to provide care, is to sue for the free care to which the plaintiff was entitled.<sup>63</sup> The statute itself does not expressly give a right to patients who are denied care to sue the medical facility, but cases interpreting the statute have held that such a right exists.<sup>64</sup> With health care costs so high, medical facilities must have more of a deterrent effect imposed upon them than the ability of a patient to sue for health care that was denied to them.<sup>65</sup>

In reality, a patient who sues for health care under the Hill-Burton Act does not break even. The Hill-Burton Act does not permit an award of attorneys fees to plaintiffs that are successful in their suits to obtain medical care to which the

62. S. REP. NO. 1285, 93d Cong., 2d Sess. 61 (1974), *reprinted in* 1974 U.S.C.C.A.N. 7860, 7900. The Senate Report stated:

While the State plans reviewed contained provisions which essentially met the Federal requirements, none of the State agencies had an active program for monitoring compliance with the requirement. Most intend to rely on complaints to monitor compliance. Also, some facilities have not informed the State agencies how they intend to meet the reasonable volume of free services requirement. This seems to the Committee to be a sorry performance by the Department and the State Hill-Burton agencies in implementing a provision which has been in law for over 20 years, and which has recently been reemphasized.

*Id.*

63. *Rapides Gen. Hosp. v. Matthews*, 435 F. Supp. 384, 387 (W.D. La. 1977) (holding that the Hill-Burton Act mandates that facilities receiving funds allocate a certain amount of care to the indigent, and failure to meet this obligation vests a cause of action in the intended beneficiaries to sue for the free care that was supposed to be furnished to them).

64. *Euresti v. Stenner*, 458 F.2d 1115, 1118 (10th Cir. 1972) (concluding that allowing a private cause of action under the Hill-Burton Act would promote the public interest and would bring about the proper enforcement procedures of the Hill-Burton Act); *Organized Migrants in Community Action, Inc. v. James Archer Smith Hosp.*, 325 F. Supp. 268, 271 (S.D. Fla. 1971) (denying the defendant's motion to dismiss and holding that the plaintiffs had standing to bring suit on their own behalf under the Hill-Burton Act); *Cook v. Ochsner Found. Hosp.*, 319 F. Supp. 603, 606 (E.D. La. 1970) ("It is a matter of the clearest logic that the only real beneficiaries of a hospital program are the people who need or may need medical treatment. This includes people of all classes, whether rich or poor."). The court concluded that the right to bring a private cause of action was implied under the Hill-Burton Act. *Id.*

65. Karen I. Treiger, *Preventing Patient Dumping: Sharpening the Cobra's Fangs*, 61 N.Y.U. L. REV. 1186, 1199-1200 (1986). "There is little incentive for hospital compliance with or HHS enforcement of Hill-Burton, neither the statute nor the regulations provide punitive measures for violations. Without fear of punishment, hospitals feel free to disregard their obligations." *Id.*

law entitles them. Thus, patients must pay legal fees to determine whether they were entitled to Hill-Burton care. The remedy that may be obtained will not compensate the patients for these fees; it will only compensate them for the care that they were denied.<sup>66</sup> In addition, indigent patients certainly do not have the resources to pay the necessary legal fees for the determination that they were denied a right to health care. Attorneys would be more likely to represent indigent plaintiffs on patient dumping claims if the patient dumping statute provided for attorneys fees.

Given this situation, patient dumping laws should include a provision that requires attorneys fees to be paid by the defendant if there is a finding that a patient's right to medical care was improperly denied.<sup>67</sup> Furthermore, patient dumping laws must pose a greater threat to medical facilities than the threat of forcing the medical facility to render care it is already obligated to provide. The law must provide for a serious remedy against medical facilities to provide an adequate deterrent effect, without forcing the facilities out of business.<sup>68</sup>

Another area of the Hill-Burton Act that poses a problem is that once a medical facility has met its quota of three percent of the overall operation costs, or ten percent of their Hill-Burton federal loans, there is no longer any duty on the part of the medical facility to provide health care to indigent patients.<sup>69</sup> Even the medical facilities that received the \$4.4 billion in grants and \$2 billion in loans through the Hill-Burton Act from 1947 to 1974 did not provide the care for the indigent that was expected of them in exchange for the loans and grants.<sup>70</sup>

A 1980 study conducted in North Dakota concluded that out of twenty-one surveyed facilities that received Hill-Burton funds, twenty of the facilities were

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66. See *supra* notes 63-65 and accompanying text.

67. The House Report for EMTALA proposed that attorneys fees should be provided in the patient dumping statute. The report stated:

The subcommittee review found that private attorneys would most likely be reluctant to bring suit to enforce the statute, unless the patient has been severely harmed by the illegal transfer, because their expenses and fees might not be paid. But the preventive effect of the statute is diluted if only those cases which command a large damage award are brought. The award of attorneys fees in successful private suits to enforce the COBRA amendment would correct this problem. As Judith Waxman, attorney for the National Health Law Center pointed out, if HHS is not enforcing the statute and if private lawyers won't bring cases, the law will become meaningless.

EQUAL ACCESS, *supra* note 2, at 19. Despite this proposal, EMTALA did not include a provision for attorneys fees. 42 U.S.C.A. § 1395dd (West Supp. 1992).

68. See *supra* notes 30-31 and accompanying text.

69. Wyoming Hosp. Ass'n v. Harris, 727 F.2d 936, 939 (10th Cir. 1984).

70. S. REP. NO. 1285 93d Cong., 2d Sess. (1974), *reprinted in* 1974 U.S.C.C.A.N. 7860.

required to provide a total of \$63,487 in extra free medical care.<sup>71</sup> In addition, fourteen out of the twenty-one facilities analyzed in the survey did not meet the amount of free care they were obliged to provide under the Act.<sup>72</sup> The Hill-Burton Act has merely put a dent in the enormous problem of patient dumping and lacks the clear terms and aggressive enforcement procedures that are needed to effectively eliminate patient dumping and provide adequate health care for the indigent.<sup>73</sup> Faced with these deficiencies, Congress made a second attempt to regulate patient dumping by enacting EMTALA.

### *B. The Emergency Medical Treatment and Women in Active Labor Act*

The most recent federal attempt to solve the patient dumping problem is the Emergency Medical Treatment and Women in Active Labor Act (EMTALA),<sup>74</sup> which was passed in 1986. EMTALA applies to all medical facilities that receive Medicaid benefits and hospitals that maintain emergency rooms.<sup>75</sup> Ninety-one percent of the hospitals in the United States receive Medicaid benefits.<sup>76</sup> EMTALA was passed in response to the growing concern that patients in need of emergency medical services were being denied care.<sup>77</sup> In addition, it was found that a large number of patients being denied emergency care were the indigent and the uninsured.<sup>78</sup> The federal response to the patient dumping problem was intended to enact penalties to prevent patient dumping.<sup>79</sup> In addition, the federal laws were intended to ensure that such penalties were not

71. Kevin O'Neil, *Site Visits at 21 Hill-Burton Facilities Reveal Extensive Noncompliance*, 16 CLEARINGHOUSE REV. 404, 407 (1985). The study further showed that of twenty-one facilities reviewed: 1) 7 out of 21 facilities did not provide the individual notice required under the Hill-Burton enforcement procedures; 2) 11 out of the 21 facilities did not have accurate written notices, and the notices used contained specific language that would tend to cause an applicant to believe that they were not eligible for the free care required under the Act; 3) 5 out of the 21 did not determine eligibility and amounts of care they were required to provide accurately; 4) 9 out of the 21 facilities used accounts for their Hill-Burton requirements that were not properly part of the care required under Hill-Burton; and 5) 15 out of 21 facilities did not have Hill-Burton records that are required to be kept, and those that did maintain records did not have complete reports. *Id.*

72. *Id.* at 411.

73. See *supra* notes 69-72 and accompanying text.

74. 42 U.S.C.A. § 1395dd (West Supp. 1992). For a discussion of EMTALA and amendments that should be created, see Thomas L. Stricter Jr., Note, *The Emergency Medical Treatment and Active Labor Act: Denial of Emergency Medical Care Because of Improper Economic Motives*, 67 NOTRE DAME L. REV. 1121 (1992); Andrew J. McClurg, *Your Money or Your Life: Interpreting the Federal Act Against Patient Dumping*, 24 WAKE FOREST L. REV. 174 (1989); Karen I. Treiger, *Preventing Patient Dumping: Sharpening the Cobra's Fang's*, 61 N.Y.U. L. REV. 1186 (1989).

75. 42 U.S.C.A. § 1395dd (West Supp. 1992).

76. Danielle L. Trostorff, *King Cobra Recoils*, 37 FEB. B. NEWS & J. 442 (1990).

77. H.R. REP. NO. 241, 99th Cong., 2d Sess., pt 3, at 5 (1986), *reprinted in* 1986 U.S.C.C.A.N. 42, 726.

78. *Id.*

79. *Id.* at 728.

so severe that hospitals would choose to close down instead of risking the fines and sanctions under EMTALA.<sup>80</sup>

EMTALA is a more successful attempt to solve the patient dumping problem than the Hill-Burton Act. EMTALA defines the essential terms necessary to determine if required care to indigent patients was properly provided.<sup>81</sup> Furthermore, EMTALA applies to almost all situations in which a patient in an emergency medical condition is dumped.<sup>82</sup> Under the Hill-Burton Act, if an indigent patient with an emergency medical condition is unlucky enough to arrive at the hospital the day after the facility fulfilled its Hill-Burton requirements, the patient is out of luck because the facility no longer has any duty to provide care to the indigent.<sup>83</sup> Moreover, even if a medical facility is still under the obligations of the Hill-Burton Act, if the patient needing care is in an area of the facility that is not part of the Hill-Burton funds, the facility is under no obligation to render care.<sup>84</sup> EMTALA also provides for remedies directly in the statute, whereas the Hill-Burton Act relies on judicial interpretations to hold that a private cause of action could be brought against a medical facility.<sup>85</sup>

EMTALA prohibits the dumping of a patient either when the patient is in an emergency medical condition or when a woman is in active labor.<sup>86</sup> Once a hospital has stabilized a patient it is free to transfer the patient even if the reasons for the transfer are economic.<sup>87</sup> An emergency medical condition is defined as a condition that could place the patient's health in serious jeopardy, result in serious impairment to bodily functions, or serious dysfunction to bodily organs.<sup>88</sup> A pregnant woman's condition is deemed to be an emergency

80. *Id.* The legislative history states, "Thus, the committee is concerned that if penalties are too severe, some hospitals, particularly those located in rural or poor areas, may decide to close their emergency rooms entirely rather than risk the civil fines and damage awards." *Id.*

81. 42 U.S.C.A. § 1395dd (West Supp. 1992).

82. *Id.* See also *infra* notes 86-97 and accompanying text.

83. See *supra* notes 44-48 and accompanying text.

84. See *supra* notes 43-47 and accompanying text.

85. See *supra* notes 63-66 and accompanying text.

86. 42 U.S.C.A. § 1395dd(b)(1) (West Supp. 1992).

87. 42 U.S.C.A. § 1395dd (West Supp. 1992).

88. *Id.* § 1395dd(d)(2)(e)(1)(A). EMTALA states:

(1) The term emergency medical condition means—

(A) A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

(i) placing the health of the individual, (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,  
 (ii) serious impairment to bodily functions, or

medical condition if there is not enough time to transfer the woman safely before she delivers the baby, or if the woman's or child's health is threatened by the transfer.<sup>89</sup>

EMTALA also requires a medical facility to give a patient an appropriate medical screening "within the hospital's capability."<sup>90</sup> After a medical facility has rendered emergency care that stabilizes a patient, the facility is permitted to transfer the patient.<sup>91</sup> EMTALA defines stabilization of a patient as, "such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer."<sup>92</sup>

Medical facilities are also permitted to transfer a patient who is in an emergency condition and has not been stabilized if the guidelines set forth in the statute are met.<sup>93</sup> One situation in which a transfer is appropriate is when the

(iii) serious dysfunction of any bodily organ or part.

*Id.*

89. 42 U.S.C.A. § 1395dd(d)(2)(e)(1)(B) (West Supp. 1992). EMTALA states the term medical emergency means:

- (B) with respect to a pregnant woman who is having contractions—
- (i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or
  - (ii) that the transfer may pose a threat to the health or safety of the woman or the unborn child.

*Id.*

90. *Id.* § 1395dd(a).

91. *Id.* § 1395dd(c).

92. *Id.* § 1395dd(e)(3)(A).

93. *Id.* § 1395dd(c)(1). EMTALA provides:

- (1) If a patient at a hospital with an emergency medical condition which has not been stabilized the hospital may not transfer the individual unless—
- (A)(i) The individual (or a legally responsible person acting on the individual's behalf) after being informed of the hospital's obligations under this section and the risk of transfer, in writing requests transfer to another medical facility.
  - (ii) A physician has signed a certification that, based upon the reasonable risks and benefits to the individual, and based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment to another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer, or
  - iii) If a physician is not present a qualified medical person has signed a certification as described in clause ii.

*Id.*

In addition, EMTALA specifies guidelines that must be followed even in situations where a transfer is appropriate:

- (2) Appropriate transfer. An appropriate transfer to a medical facility is a transfer—
- (A) In which the transferring hospital provides the medical treatment

patient or the patient's legal representative requests that a transfer be made.<sup>94</sup> In addition, a physician may determine that, based on the risks and benefits involved, a transfer is in the patient's best interest.<sup>95</sup> If a physician makes this determination, he or she must sign a certification stating that the transfer is in the patient's best medical interest.<sup>96</sup>

If a medical facility violates EMTALA by not stabilizing patients before transferring them or by failing to meet the guidelines for a proper transfer when patients are in an unstable condition, civil monetary penalties are imposed.<sup>97</sup> A hospital or physician that violates EMTALA may incur a monetary penalty of up to \$50,000.<sup>98</sup> In addition to this civil monetary penalty, a private cause of action for personal harm may be brought and relief granted under the law of the state where the hospital is located.<sup>99</sup>

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within its capacity which minimizes the risk to the individual's health and, in the case of a woman in labor, the health of the unborn child;

(B) In which the receiving facility —

(i) Has available space and qualified personnel for the treatment of the individual, and

(ii) Has agreed to accept transfer of the individual and to provide appropriate medical treatment;

(C) In which the transferring hospital sends to the receiving facility all medical records (or copies thereof), related to the emergency condition for which the individual has presented, available at the time of the transfer, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) provided under paragraph (1)(A), and the name and address of any on-call physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment;

(D) In which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and

(E) Which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of individuals transferred.

*Id.* § 1395dd(c)(2).

94. *Id.* § 1395dd(c)(1)(A)(i).

95. *Id.*

96. *Id.* § 1395dd(c)(A)(ii).

97. *Id.* § 1395dd(d)(1). The approach of EMTALA can be contrasted with the approach of the Hill-Burton Act in federal attempts to create medical care for the indigent. Under the Hill-Burton Act, there were no affirmative penalties to be imposed against a medical facility that refused to comply with the requirement that it provide charity medical care. EMTALA goes further than the Hill-Burton Act, though, because it contains clear enforcement provisions within the regulation itself. However, EMTALA, like the Hill-Burton Act, is not being enforced aggressively. See *infra* notes 160-64 and accompanying text for a discussion of the enforcement of EMTALA.

98. *Id.* § 1395dd(d)(1)(B)(ii).

99. *Id.* § 1395dd(d)(2)(A).

A medical facility may be relieved of liability under EMTALA if a patient refuses to consent to treatment and examination by the facility.<sup>100</sup> In addition, if a patient, after being informed of the risks and benefits of a transfer, refuses to consent to such a transfer, the medical facility is deemed to have complied with giving the patient a proper medical screening.<sup>101</sup> The medical facility bears the burden of proving that the patient initially requested treatment and then refused the offered treatment.<sup>102</sup> The lack of clear terms and definitions in EMTALA has caused courts to attempt to fill in the gaps of the statute, which has resulted in inconsistencies in the case law. The next aspect of EMTALA to be examined is the jurisprudential interpretations that have attempted to fill the gaps in the federal statute.

### III. JUDICIAL INTERPRETATIONS OF EMTALA

#### A. Recovery of Personal Harm Damages Against a Physician

Courts have a divided approach as to whether a plaintiff can recover damages for personal harm against a physician under EMTALA. The specific language of the statute does not provide for a cause of action for personal harm against a physician.<sup>103</sup> Because the statute clearly spells out that civil monetary penalties may be imposed against both the hospital and the physician,<sup>104</sup> the plain language of the statute indicates that damages for personal harm are not available against a physician.<sup>105</sup>

Most courts have followed this approach and have denied plaintiffs a cause of action for personal harm against physicians.<sup>106</sup> Courts that apply this

100. *Id.* at 1395dd(b)(2). The hospital is required to take all reasonable steps to obtain written informed consent of the patient's refusal of treatment.

101. *Id.* at 1395dd(b)(3).

102. *Stevison v. Enid Health Sys., Inc.*, 920 F.2d 710, 713 (10th Cir. 1990) (reversing a jury verdict where the jury had improperly been instructed that the plaintiff had the burden of proving that a request for emergency medical treatment was not withdrawn). The court held that once the plaintiff satisfied the initial burden of showing that a request for treatment was made, the burden shifted to the defendant to show by a preponderance of the evidence that the request made by the plaintiff was withdrawn. *Id.*

103. 42 U.S.C.A. 1395dd(d)(2)(A) (West Supp. 1992).

104. *Id.* at 1395dd(d)(1).

105. *Id.*

106. *Delaney v. Cade*, 756 F. Supp. 1476, 1487 (D. Kan. 1991) (granting the physician's motion for summary judgment on the EMTALA claim, and stating, "[I]f Congress had intended to create a private cause of action against the physician it knew how to do so"), *aff'd in part, rev'd on other grounds*, 986 F.2d 387, 394 (10th Cir. 1993); *Baber v. Hospital Corp. of Am.*, 977 F.2d 872, 878 (4th Cir. 1992) (upholding a summary judgment for the defendant physicians, and stating, "The clear language of EMTALA, supported by its legislative history, provides no basis for a patient to recover personal injury damages from her physician"); *Richardson v. Southwest Mississippi*

reasoning limit recovery against the physician to normal medical malpractice damages.<sup>107</sup> These courts emphasize that the legislative history of EMTALA clearly spells out the parties who can bring a lawsuit for patient dumping.<sup>108</sup> These courts have held that Congress only intended for the Department of Health and Human Services to bring a cause of action against physicians.<sup>109</sup> Because the clear language of the statute does not allow for a cause of action against the physician, the courts have been reluctant to second-guess Congress and allow for a private cause of action against the physician.<sup>110</sup>

In *Sorrells v. Babcock*,<sup>111</sup> the court stated in dicta that it may be possible for a private party to bring a cause of action against a physician under EMTALA.<sup>112</sup> The court emphasized that the legislative history of EMTALA shows that there is a strong need to hold physicians responsible for the denial of medical care to patients in emergency medical conditions.<sup>113</sup> The court found that there was federal subject matter jurisdiction over the defendant doctor whether the plaintiff was permitted to recover a civil monetary penalty or whether only the governmental entity could impose such civil fines.<sup>114</sup> The court stated, "It would be a strange situation indeed for an individual to bring a civil suit so that a governmental entity could recover a monetary penalty."<sup>115</sup> The court went on to say, "the court does not see why an individual would expend the monies and the time necessary in bringing the civil suit when he or she would not benefit in a favorable outcome. The court cannot fathom that Congress would have intended such a result."<sup>116</sup>

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Regional Medical Ctr., 794 F. Supp. 198 (S.D. Miss. 1992) (holding that EMTALA does not create a private cause of action against a physician); *Jones v. Wake County Hosp. Sys. Inc.*, 786 F. Supp. 538, 545 (E.D.N.C. 1991) (dismissing the plaintiff's claim against the defendant physician, and holding that "[i]t would be inconsistent with the plain language of the statute to infer a private cause of action against the physician and the court refuses to do so"); *Lavignette v. West Jefferson Medical Ctr.*, 1990 U.S. Dist. LEXIS, 14966 at \*4 (E.D. La. Nov. 7, 1990) (holding that the plaintiff could not maintain a cause of action for patient dumping against the physician, but that the plaintiff could obtain relief under the state medical malpractice law).

107. *Jones*, 786 F. Supp. at 545.

108. *Id.*

109. *Baber*, 977 F.2d at 872.

110. *Id.* at 878.

111. 733 F. Supp. 1189 (N.D. Ill. 1990), *summ. judgment granted*, 1992 U.S. Dist. LEXIS 17148 (N.D. Ill. 1992). In this case, the plaintiff brought a cause of action for patient dumping after being discharged while suffering from severe complications of gastrointestinal bleeding. Summary judgment was granted because the court found that "the plaintiff failed to show that the delay in diagnosis proximately caused her injury." *Id.* at 1194.

112. *Id.*

113. *Id.*

114. *Id.*

115. *Id.*

116. *Id.*

One of the problems in relation to EMTALA is that hospitals cannot control physicians.<sup>117</sup> One attorney stated, "The fact is that most hospitals function under the political reality that the physicians call the shots."<sup>118</sup> If the physicians are in reality calling the shots in the emergency medical care services, an effective provision against patient dumping must hold the physicians individually responsible for their actions that lead to patient dumping.

### B. Requirement that the Plaintiff Actually Arrive in the Emergency Room

Recent cases have attempted to clarify whether arrival by a patient in the hospital's emergency room is a prerequisite to filing a claim for patient dumping under EMTALA.<sup>119</sup> The section of EMTALA that explains the required medical screening requirement specifically states that a hospital has a duty to screen any individual who comes to the emergency department and requests an examination or treatment.<sup>120</sup> However, the sections of EMTALA requiring that the patient's condition be stabilized<sup>121</sup> and forbidding transfers unless the patient is stable<sup>122</sup> do not include any specific language about the individual arriving at the emergency department.<sup>123</sup>

117. Terese Hudson, *Attorneys Fear Patient Transfer Claims in Medical Malpractice Cases*, HOSPITALS, April 5, 1991, at 44. Hospitals are described as, "not where the doctor practices medicine, but the hospital is where medical care is delivered using physician and health care personnel." *Id.*

118. *Id.* The attorney gave the example of one hospital that required all on-call physicians to assist patients whether they were indigent or not, and the entire medical staff quit. The hospital then withdrew the requirement. *Id.*

119. *Thornton v. Southwest Detroit Hosp.*, 895 F.2d 1131, 1135 (6th Cir. 1990) (holding that a patient who was admitted to the intensive care unit, then spent time in regular in-patient care, could bring a cause of action for patient dumping, but finding that the plaintiff was not discharged while in an emergency medical condition); *McIntyre v. Schick*, 795 F. Supp. 777, 780 (E.D. Va. 1992) (holding that a patient who did not enter the hospital for treatment through the emergency room did not fail to state a claim for patient dumping); *Loss v. Song*, 1990 U.S. Dist. LEXIS 14812 at \*9 (N.D. Ill. Nov. 6, 1990) (holding that where a mother gave birth to a child with a medical emergency condition, failure of the child to arrive at the hospital emergency room did not preclude a claim for patient dumping under EMTALA).

120. 42 U.S.C.A. § 1395dd(a) (West 1992). The medical screening requirement states, in relevant part, "If any individual comes to the emergency department and a request is made on the individual's behalf for an examination or treatment for a medical condition the hospital must provide for an appropriate screening examination." *Id.*

121. *Id.* § 1395dd(b). This section of EMTALA states, in relevant part, "If any individual comes to a hospital and the hospital determines that the individual has an emergency medical condition. . . ." *Id.* Clearly, this section of EMTALA does not require that the care being rendered to the patient in an emergency medical condition be in the emergency room. *Id.*

122. *Id.* § 1395dd(c). This section of EMTALA also uses the term "hospital" in describing the duties required under the statute. The specific term "hospital emergency room" is not mentioned.

123. *Id.*

In the recent case of *McIntyre v. Schick*,<sup>124</sup> the plaintiff brought a cause of action under EMTALA based on patient dumping. After the plaintiff arrived at the hospital with labor contractions,<sup>125</sup> the hospital kept the plaintiff at the hospital for eleven hours and twenty-five minutes, but she was never formally admitted.<sup>126</sup> The plaintiff was then sent home.<sup>127</sup> The plaintiff returned to the hospital the next day, and was found to be in a serious medical condition.<sup>128</sup> The plaintiff gave birth to an anemic baby boy who died a few days after birth.<sup>129</sup> The defendant hospital attempted to bring a motion to dismiss based on the fact that the plaintiff did not allege in her complaint that she presented herself to the emergency room.<sup>130</sup>

The court denied the motion to dismiss, finding that the plaintiff had stated a claim under EMTALA, and that claims could be brought under EMTALA for patient dumping that occurred in areas of the hospital other than the hospital emergency room.<sup>131</sup> The court emphasized that Congress' purpose in enacting EMTALA was to provide emergency care to all patients, regardless of in which section of the hospital the care was rendered.<sup>132</sup>

*Loss v. Song*<sup>133</sup> further expanded the scope of EMTALA by holding that patients need not present themselves to the emergency room to obtain relief under EMTALA.<sup>134</sup> In *Loss*, the plaintiff was admitted to the defendant

124. 795 F. Supp. 777, 780 (E.D. Va. 1992). The court analyzed the specific language of EMTALA and concluded that the wording of the statute is inclusive of patients in all areas of the hospital, not just the hospital emergency room. The court further stated that there was no requirement that a person present themselves first in the hospital emergency room to be able to bring a cause of action for patient dumping. *Id.*

125. *Id.* at 778.

126. *Id.*

127. *Id.*

128. 795 F. Supp. 777, 778 (E.D. Va. 1992).

129. *Id.*

130. *Id.*

131. *Id.* at 781. The court stated:

Although emergency care often occurs, and almost always invariably begins, in an emergency room, emergency care does not always stop when a patient is wheeled from the emergency room into the main hospital. . . . The rationale behind the patient anti-dumping statute is not based upon the door of the hospital through which the patient enters, but rather upon the notion of proper medical care for those persons suffering from medical emergencies, whenever such emergencies occur at a participating hospital. Indeed, it is a ridiculous distinction, one which places form over substance, to state that the care a patient receives depends on the door through which the patient walks.

*Id.* (quoting in part from *Thornton v. Southwest Detroit Hosp.*, 895 F.2d 1131 (6th Cir. 1990)).

132. *Id.* at 780.

133. 1990 U.S. Dist. LEXIS 14812, at \*1 (N.D. Ill. Nov. 6, 1990).

134. *Id.*

hospital and gave birth to a child who had an emergency medical condition.<sup>135</sup> The mother and child were discharged, and the mother alleged that the child was discharged while in an emergency medical condition that was not properly stabilized by the hospital.<sup>136</sup> The court held that a claim could be brought on behalf of the child under EMTALA even though the child never went to the emergency room because the child was not yet born.<sup>137</sup> The court found that when the hospital admitted a pregnant woman, the hospital was in effect also admitting the child, a separate person not yet born.<sup>138</sup>

EMTALA was further expanded in *Smith v. Richmond Memorial Hospital*,<sup>139</sup> where the court held that a cause of action for patient dumping could be brought when the patient was first admitted to the hospital and stabilized, and then allowed to become unstable and transferred while the unstable condition persisted.<sup>140</sup> *Smith* shows the continuation of the courts' interpretations that EMTALA does not require that patient dumping take place at any particular time of treatment or at any particular department of the hospital.<sup>141</sup>

135. *Id.*

136. *Id.* at \*2.

137. The court did not agree with the defendant's argument that the language in EMTALA meant to require emergency medical care only in the hospital emergency room. The court stated that Congress' purpose was to insure that all patients with medical emergencies receive the appropriate medical care. *Id.* at \*7.

138. *Id.* at \*9.

139. 416 S.E.2d 689, 692 n.140 (Va. 1992), *cert. denied*, 113 S. Ct. 442 (U.S. 1992).

140. *Smith*, 416 S.E.2d at 692 (Va. 1992). The court emphasized that patient dumping while an emergency medical condition exists is not to be tolerated from any aspect of the medical facility. The court stated:

Patient dumping is not limited to a refusal to provide emergency room treatment. It occurs, and is equally reprehensible, at any time a hospital determines that a patient's condition may result in substantial medical costs and the hospital transfers the patient because it fears it will not be paid for those expenses. Dumping a patient in this manner is neither related to, nor dependent on, the patient arriving through the emergency room and never being stabilized.

*Id.* *But see* *Collins v. DePaul Hosp.*, 963 F.2d 303, 307 (10th Cir. 1992) (stating that it must be established that the plaintiff went to the hospital's emergency room with an emergency medical condition); *Daniels v. Wills Eye Hosp.*, 1992 U.S. Dist. LEXIS 7396 at \*6 (E.D. Pa. May 7, 1992) (stating that a plaintiff suing under EMTALA must allege that he went to the defendant's emergency room); *DeBerry v. Sherman Hosp.*, 741 F. Supp. 1302, 1305 (N.D. Ill. 1990) (stating that a plaintiff suing under EMTALA must allege, 1) he went to the defendant's emergency room, 2) with an emergency medical condition, and that the hospital either 3) did not adequately screen him to determine whether he had such a condition, or 4) discharged or transferred him before the emergency condition had been stabilized), *summ. judgment granted*, 769 F. Supp. 1030 (N.D. Ill. 1991) (finding that "there was no showing by the plaintiffs that the hospital knowingly failed to conduct an appropriate screening examination under § 1395dd," so a summary judgment was granted).

141. *Id.*

In *Johnson v. University of Chicago Hospitals*,<sup>142</sup> the court refused to extend EMTALA beyond the physical premises of the hospital to a hospital's telemetry operator.<sup>143</sup> *Johnson* restricted the general line of cases that held that arrival in the emergency room is not a requirement for a claim to be stated under EMTALA.<sup>144</sup> In *Johnson*, the district court held that the EMTALA provisions did not apply to a patient who was in an ambulance and was directed to a hospital by a mobile intensive care system tertiary operator.<sup>145</sup> The plaintiff claimed that the infant patient was directed to a hospital while in an unstable condition and that being directed to the hospital where treatment was rendered was not in the infant's best interest, but in the hospital's best economic interest.<sup>146</sup>

The court of appeals initially found that even though the patient sought care through the hospital's telemetry and paramedic systems, EMTALA applied to the case and the plaintiff could bring a cause of action for patient dumping.<sup>147</sup> However, a later court of appeals decision reversed this finding, and held that the plaintiff could not recover under EMTALA because the plaintiff had never come to the hospital emergency room, which is a requirement for a recovery based on EMTALA.<sup>148</sup>

The court of appeals held that a hospital's telemetry system was separate and distinct from the hospital's emergency room, and it refused to extend EMTALA to cover the telemetry system.<sup>149</sup> This decision has created an opportunity for hospitals to evade causes of action under the patient dumping

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142. 982 F.2d 230 (7th Cir. 1992).

143. *Id.* at 233. Another example of a woman who never actually presented herself to the hospital emergency room, yet was within the reach of the hospital if it chose to help her, was Liza Cruz. Cruz was a 62-year-old woman who was injured when her car overturned. She was 40 feet from a hospital emergency room, but when witnesses went to the hospital to obtain help, the hospital stated that the woman would have to wait for an ambulance service to pick her up. Ms. Cruz waited 30 minutes before an ambulance picked her up and delivered her to the nearby hospital. Jo Ann Zuniga, *A Hospital So Close But Yet So Far Away*, THE HOUSTON CHRON., December 8, 1992, at 17.

144. See *supra* notes 119-41 and accompanying text.

145. *Johnson v. Univ. of Chicago Hosp.*, 774 F. Supp. 510, 513 (N.D. Ill. 1991), *aff'd in part, rev'd in part* 1992 U.S. App. LEXIS 25096 (7th Cir. Oct. 7, 1992), *vacated* 1992 U.S. App. LEXIS 31109 (7th Cir. Nov. 23, 1992), *aff'd in part, rev'd in part* 982 F.2d 230 (7th Cir. 1992).

146. *Id.*

147. *Johnson*, U.S. App. LEXIS 25096 at \*11 (7th Cir. Oct. 7, 1992) ("Although the Act refers to individuals who come to the hospital, we agree with Ms. Johnson's assertion that an individual can seek medical assistance from a hospital through telemetry communications and paramedic services without coming to the hospital's emergency room.")

148. *Johnson*, 982 F.2d 230, 233 (7th Cir. 1992). The court did state, "Although a hospital could conceivably use a telemetry system in a scheme to dump patients, the statute does not expressly address the question of liability in such a situation." *Id.* at 233 n.7.

149. *Id.*

laws. Under the *Johnson* decision, if a hospital can prevent a patient from ever getting to the emergency room, the hospital can effectively avoid treating the patient without being liable for patient dumping. This situation directly conflicts with previous cases holding that arrival or presence in the hospital emergency room is not a requirement for a claim of patient dumping and is the type of situation the courts sought to prevent.<sup>150</sup> Under the approach in *Johnson*, the more effectively the hospital prevents the availability of emergency care so that patients never get close to the emergency room, the more likely it is the hospital will be able to avoid the patient dumping laws.

### *C. Requirement that Indigency be Alleged by the Plaintiff*

The issue of whether an allegation of indigency is required for a claim under EMTALA is another area where courts are split in their interpretations. Some courts have held that a plaintiff must base a claim for patient dumping on the fact that the patient was denied treatment because of economic motives of the medical facility.<sup>151</sup> Courts that take this approach reason that if indigency is not an element required for a patient dumping claim, then any patient who is not satisfied with the medical treatment they are given could bring a cause of action under EMTALA, and this would be extending the federal statute further than necessary.<sup>152</sup>

Other courts have held that EMTALA protects any person who is denied

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150. See *supra* notes 119-41 and accompanying text.

151. *Coleman v. McCurtain Memorial Medical Management*, 771 F. Supp. 343, 347 (E.D. Okla. 1991) (finding the plaintiff's claim to be one of misdiagnosis, not a claim for patient dumping); *Stewart v. Myrick*, 731 F. Supp. 433, 436 (D. Kan. 1990) (finding that this case does not "represent a case of patient dumping, in which the plaintiff was turned away from medical care for economic reasons. As a result, the case does not present the type of evil that Congress sought to eliminate in the Act, and the federal claim will be dismissed."); *Nichols v. Eastabrook*, 741 F. Supp. 325, 330 (D.N.H. 1989). The court held that the legislative history of EMTALA "reveals the Congressional intent behind the Act: to provide some assurance that patients with emergency medical conditions will be examined and treated regardless of their financial resources. Plaintiffs here do not allege that their financial condition or lack of health insurance contributed to Dr. Eastabrook's decision not to treat their son. The interest which Congress sought to protect by enacting 42 U.S.C. § 1395dd was not invaded by the defendant's conduct as here alleged . . . ." *Id.* See also *Evitt v. University Heights Hosp.*, 727 F. Supp. 495, 497 (S.D. Ind. 1989) (finding that where plaintiff alleged that her medical condition was misdiagnosed, but her inaccurate treatment was not based on indigency, the cause of action was for medical malpractice, not patient dumping under EMTALA).

152. *Evitt*, 727 F. Supp. at 497. Courts reason further that patients will be adequately compensated for an improper or inappropriate medical screening by bringing a state medical malpractice claim. *Id.*

emergency treatment regardless if the person is indigent.<sup>153</sup> These courts base such a holding on the plain language of EMTALA, which states that "any individual" may bring a patient dumping suit if that individual is denied treatment.<sup>154</sup> The courts further reason that there is no requirement that a plaintiff be indigent to recover under the statute.<sup>155</sup> Given the nature of the patient dumping problem, adding the requirement that a plaintiff allege indigency would create unnecessary hurdles for plaintiffs, and would lessen the deterrent effect of the patient dumping statute. Hospitals may dump patients who appear to be uninsured and unable to pay for the services, but in fact those patients may be able to pay or they may have health insurance that will cover the services. Such cases would be no less serious than a hospital dumping a patient who is in fact indigent, and these cases should be treated no differently under the law.

#### D. Failure of EMTALA in Preventing Patient Dumping

Another problem with EMTALA is that it does not apply when a hospital misdiagnoses or fails to diagnose an emergency condition.<sup>156</sup> If no emergency condition is found by the hospital, then no cause of action is available based on

153. *Collins v. DePaul Hosp.*, 963 F.2d 303, 308 (10th Cir. 1992); *Brooker v. Desert Hosp.*, 947 F.2d 412, 415 (9th Cir. 1991); *Cleland v. Bronson Health Care Group*, 917 F.2d 266, 270 (6th Cir. 1990); *Urban v. King*, 783 F. Supp. 560, 562 (Kan. 1992); *Burrows v. Turner Memorial Hosp.*, 762 F. Supp. 840, 842 (W.D. Ark. 1991); *Gatewood v. Washington Healthcare Corp.*, 933 F.2d 1037, 1040 (D.O.C. 1991).

The court in *Cleland v. Bronson Health Care Group* stated:

We can think of many reasons other than indigency that might lead a hospital to give less than standard attention to a person who arrives at the emergency room. These might include: prejudice against the race, sex, or ethnic group of the patient; distaste for the patient's condition (e.g., AIDS patients); personal dislike or antagonism between the medical personnel and the patient; disapproval of the patient's occupation; or political or cultural opposition. If a hospital refused treatment to persons for any of these reasons, or gave cursory treatment, the evil inflicted would be quite akin to that discussed by Congress in the legislative history of EMTALA, and the patient would fall squarely within the statutory language.

*Cleland*, 917 F.2d at 272.

For a detailed discussion of discrimination in health care against AIDS patients, see Joseph Reiner, *Aids Discrimination By Medical Care Providers: Is Washington Law An Adequate Remedy?* 63 WASH. L. REV. 701 (1988).

154. *Cleland*, 917 F.2d at 272.

155. *Gatewood*, 933 F.2d at 1040. While the court found no need for indigency to be alleged, it did require that a screening process be done in a manner which evidences differential treatment of the patient. However, the court stated that it did not require an improper motive on the part of the hospital, only that the screening that was done was improper. The court held that if a case involved a misdiagnosis or failure to diagnose a problem, the case should be resolved based on medical malpractice law. *Id.* at 1041.

156. 42 U.S.C.A. § 1395dd(b)(1) (West 1992). The specific language of the statute describes the necessary duties of the hospital in light of the fact that it has been established that the patient is suffering from an emergency medical condition. *Id.*

patient dumping.<sup>157</sup> The court in *Mitchell v. Candler*<sup>158</sup> stated in dicta that this creates a loophole in EMTALA: because hospitals can shield themselves from liability by falsely diagnosing a condition as non-emergency, the hospital's duty to stabilize does not arise until an emergency condition has been established.<sup>159</sup> Under this analysis, a hospital itself can set a very low standard of care for determining emergency conditions. Patients should be permitted to bring patient dumping claims, and a judge or jury, not the hospital or doctors, should apply objective standards and determine if under the circumstances the patient was in an emergency condition.

In enforcement and application, EMTALA has enjoyed little success. Since EMTALA's enactment in 1986, 149 hospitals were found to have violated EMTALA.<sup>160</sup> Only thirteen of these hospitals have been penalized for their violations of EMTALA.<sup>161</sup> The total amount of fines these hospitals paid was \$479,500.<sup>162</sup> There were 121 hospitals in violation of EMTALA that were never punished.<sup>163</sup> In light of the statistics that 250,000 patients are being dumped each year,<sup>164</sup> EMTALA appears to have had little impact on the problem of patient dumping.

Sixty-seven of the 149 EMTALA violations identified and investigated were in Texas.<sup>165</sup> The spokesperson for the Health Care Financing Administration<sup>166</sup> stated that the difference in the regions could be attributed to the existence of Texas' patient dumping statute.<sup>167</sup> The small number of patient dumping cases filed under EMTALA is attributed to the fact that most people

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157. *Mitchell v. Candler General Hosp.*, 1992 U.S. Dist. LEXIS 5997 at \*14 (S.D. Ga. April 2, 1992). The court stated, "The plain language of the Act, however, makes it apparent that the hospital's duty to stabilize does not arise until the hospital recognizes and diagnoses an emergency medical condition." *Id.*

158. *Id.*

159. *Id.* at \*18.

160. Lynn Wagner, *Group Says Government is Lax in Enforcing Patient-Dumping Law*, MOD. HEALTHCARE, April 29, 1991, at 18. Most of the hospitals evaluated had violated the provision against illegal transfers. *Id.*

161. *Id.*

162. *Id.* In addition, three of the hospitals found to be in violation of EMTALA were temporarily barred from participation in Medicaid, and three hospitals were permanently removed from the Medicaid program.

163. *Id.*

164. See *supra* note 8 and accompanying text.

165. Wagner, *supra* note 160, at 18.

166. The Health Care Financing Administration (HCFA) "has primary responsibility for enforcing [the antidumping law], and the Office of the Inspector General (OIG) is responsible for applying certain sanctions under the statute." EQUAL ACCESS, *supra* note 2, at 2.

167. See *Health Care, Public Citizen Calls HHS' Enforcement of Patient Dumping Act 'Tragic Failure'*, DAILY REPORT FOR EXECUTIVES, April 24, 1991, at A-14.

are unaware of the law or the rights that they have under the law.<sup>168</sup> The fact that a greater number of patient dumping cases have been filed in Texas and California is attributed to the fact that those states have enacted state patient dumping laws which have been brought to the attention of the citizens.<sup>169</sup> States may enact their own patient dumping laws that are more vigorously applied than the federal law as long as the state law is not in direct conflict with EMTALA.<sup>170</sup>

#### IV. THE OVERLAP BETWEEN EMTALA AND STATE MEDICAL MALPRACTICE LAW

Courts have varied in interpreting the relationship between the EMTALA "appropriate medical screening" standard and the medical malpractice standard of care under state law. Some courts have held that EMTALA does not cover a negligent medical screening, or even a screening that would clearly constitute medical malpractice.<sup>171</sup> These courts emphasize that the purpose of EMTALA is not to ensure that a patient receives an accurate diagnosis, but to ensure that patients are given an appropriate screening without considering improper factors, such as indigency, in the treatment.<sup>172</sup> It is difficult to see how a medical

168. "The success of such a law as [EMTALA] depends on the perception by doctors and hospitals of strong enforcement and penalties for violations, as well as on a broad campaign to educate patients of their rights under the law." EQUAL ACCESS, *supra* note 2, at 20.

169. See *infra* notes 217-32 for a discussion of the California and Texas patient dumping laws.

170. 42 U.S.C.A. 1395dd(f) (West Supp. 1992). "The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section." *Id.*

171. Mitchell v. Candler General Hosp., U.S. Dist. LEXIS 5997 at \*13 (S.D. Ga. April 2, 1992). The court emphasized that a claim under EMTALA does not incorporate state medical malpractice law into the inquiry whether an appropriate medical screening was provided. *Id.*

In *Baber v. Hosp. Corp. of America*, the court stated:

While EMTALA requires a hospital emergency department to apply its standard screening uniformly, it does not guarantee that the emergency personnel will correctly diagnose a patient's condition as a result of this screening. The statutory language clearly indicates that EMTALA does not impose on hospitals a national standard of care in screening patients. Had Congress intended to require hospitals to provide a screening examination which comported with generally accepted medical standards, it could have clearly specified a national standard.

*Baber v. Hospital Corp. of America*, 977 F.2d 872 (4th Cir. 1992) (concluding that, "Ms. Baber's screening was not so substandard as to amount to no screening at all"). See also *Woessner v. Freeport Memorial Hosp.*, 1993 U.S. Dist. LEXIS 160 at \* 10 (W.D. Ill. Jan. 11, 1993). The *Woessner* court stated, "[T]he issue is not whether the hospital conformed to a standard of care as recognized under state negligence law, but whether the hospital conformed to its own standard emergency room procedures for treating similarly situated patients." *Id.*

172. *Jones v. Wake County Hosp. Sys.*, 786 F. Supp. 538 (E.D.N.C. 1991). However, basing the EMTALA cause of action on whether improper factors were considered in the treatment becomes increasingly difficult in light of decisions holding that indigency is not required to be a factor alleged in a cause of action for patient dumping. See *supra* notes 151-55 and accompanying text.

screening could be appropriate if it is inaccurate. The only way to determine that someone is suffering from an emergency medical condition is to give them a diagnosis that is accurate and will determine their state of health.

There are strategic advantages to bringing a cause of action for patient dumping concurrently with a state medical malpractice claim. One attorney stated that patient transfer violations are the second or third most common cause of action in medical malpractice suits.<sup>173</sup> Hospitals are more willing to settle claims that involve patient dumping rather than going through a public trial.<sup>174</sup> In addition, the plaintiff can bring the cause of action in federal court instead of state court, where traditional claims of medical malpractice must be brought.<sup>175</sup> Procedural requirements such as submission of the medical malpractice claim to a review board may also be waived in federal court if the federal patient dumping law is found to preempt the state procedural rule.<sup>176</sup> The plaintiff may have a further advantage because under EMTALA the plaintiff can recover against the hospital, while under general medical malpractice law the plaintiff would only have a cause of action against the physician.<sup>177</sup> However, recent cases have held that a hospital can be found liable for the common law negligence of emergency room physicians based on a duty on the part of the hospital to supervise the physicians.<sup>178</sup>

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173. Terese Hudson, *Attorneys Fear Patient Transfer Claims in Medical Malpractice Cases*, HOSPITALS, April 5, 1991, at 44.

174. *Id.*

175. Demetrios G. Metropoulos, *Son of Cobra: The Evolution of a Federal Malpractice Law*, 45 STAN. L. REV. 263, 284 (1992). "Two benefits that have already been realized in the federal forum are liberal notice pleading rules and a federal court's wide latitude in admitting expert testimony. This latter advantage is especially important because expert testimony is often essential to prove professional negligence." *Id.* at 285.

Counsel for the Chicago-based American Hospital Association stated, "These lawsuits are examples of malpractice cases getting into federal court. Using the statute just to get into federal court to avoid medical liability reforms or take advantage of federal court rules of discovery, for example, just uses up everybody's resources for cases that should be in state court." Eleanor Kerlow, *How To Beat A State Malpractice Cap: Plaintiff's Bar Turns To Patient Dumping Law*, LEGAL TIMES, September 14, 1992, at 2.

176. *See infra* note 188 and accompanying text.

177. Metropoulos, *supra* note 175, at 284.

In a state medical malpractice action, the plaintiff usually can recover only from the negligent physician. The traditional tort doctrine of respondeat superior, or employer liability for employee torts, seldom applies to hospitals because they usually do not employ physicians. Instead, hospitals merely grant physicians the privilege of using hospital facilities as independent contractors.

*Id.*

178. *Bost v. Riley*, 262 S.E.2d 391 (N.C. App. 1980). The court stated, "[A] patient at a modern day hospital has the reasonable expectation that the hospital will attempt to cure him. . . . The hospital has the duty to make a reasonable effort to monitor and oversee the treatment which is prescribed and administered by physicians practicing at the facility." *Id.* at 396. *See also* *Darling v. Charleston Community Memorial Hosp.*, 211 N.E.2d 253 (Ill. 1965) (finding the hospital

The distinction between a patient who is suing under patient dumping laws and malpractice is difficult to see in light of recent decisions holding that there is no requirement that the plaintiff allege that indigency was a factor in the denial of their emergency medical care.<sup>179</sup> Further, recent decisions holding that a patient who is admitted and treated, then becomes unstable, may have a cause of action for patient dumping, blurs the medical malpractice overlap even further.<sup>180</sup> Most plaintiffs bring concurrent actions for medical malpractice and patient dumping under EMTALA.<sup>181</sup>

In light of the confusion the courts have had in determining what constitutes an appropriate medical screening under EMTALA, and what constitutes medical malpractice, patient dumping laws should clearly state that the standard for an appropriate medical screening in patient dumping is not a medical malpractice standard. Garden variety medical malpractice claims should not be brought in federal courts simply because a claim for patient dumping under EMTALA is also being alleged. The patient dumping statutes could deter plaintiffs from suing under EMTALA as an alternative to medical malpractice by lowering the recovery amount under the patient dumping law. The purpose of the patient dumping law is to deter hospitals from dumping patients, not to give plaintiffs a double recovery for medical malpractice.

Because states have enacted several measures, such as state medical malpractice caps on damages<sup>182</sup> and mandatory submission of claims to

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negligent in failing to supervise a physician in the emergency room), *cert. denied*, 383 U.S. 946 (1966).

179. See *supra* notes 151-55 and accompanying text.

180. See *supra* notes 139-41 and accompanying text.

181. See, e.g., *Baber v. Hosp. Corp. of America*, 977 F.2d 872 (4th Cir. 1992); *Abercrombie v. Osteopathic Hosp. Founders Assoc.*, 950 F.2d 676, 678 (10th Cir. 1991); *Richardson v. Southwest Mississippi Regional Medical Ctr.*, 794 F. Supp. 198, 201 (S.D. Miss. 1992); *Foster v. Lawrence Memorial Hosp.*, 1992 U.S. Dist. LEXIS 15417 at \*2 (D. Kan. Sept. 11, 1992); *Coleman v. McCurtain Memorial Medical Management*, 771 F. Supp. 343 (E.D. Okla. 1991); *Jones v. Wake County Hosp. Sys. Inc.*, 786 F. Supp. 538 (E.D.N.C. 1991); *Sorrels v. Babcock*, 733 F. Supp. 1189, 1191 (N.D. Ill. 1990).

182. For a detailed discussion of medical malpractice caps, see Walter Gellhorn, *Medical Malpractice Litigation (U.S.)*, *Medical Mishap Compensation* (N.Z.), 73 CORNELL L. REV. 170 (1988); Amanda E. Haiduc, Note, *A Tale of Three Damage Caps: Too Much, Too Little and Finally Just Right*, 40 CASE W. RES. L. REV. 825 (1990); Nancy L. Manzer, *1986 Tort Reform Legislation: A Systematic Evaluation of Caps on Damages and Limitations on Joint and Several Liability*, 73 CORNELL L. REV. 628 (1988); Mitchell S. Berger, Note, *Following the Doctor's Orders—Caps on Non-Economic Damages in Medical Malpractice Cases*, 22 RUTGERS L.J. 173 (1991).

For a discussion of the Indiana Medical Malpractice Act, see Eleanor D. Kinney et al., *Indiana's Medical Malpractice Act: Results of a Three-Year Study*, 24 IND. L. REV. 1275 (1991).

medical review panels,<sup>183</sup> it is important that EMTALA not create a federal cause of action for medical malpractice, which would not contain these state-enacted safeguards. The recent case of *Powers v. Arlington Hospital*,<sup>184</sup> demonstrates how a plaintiff can bring a cause of action under EMTALA and recover more than four times the monetary amount that would be permitted by the state medical malpractice laws.<sup>185</sup> The court in *Powers* ruled that a claim for patient dumping under EMTALA is not limited to state medical malpractice damages because EMTALA creates a federal cause of action, not a supplemental state medical malpractice action.<sup>186</sup> If exceptionally high awards are permitted under patient dumping laws, it is likely that the ultimate result will be the closure of hospitals and medical facilities due to financial burdens.<sup>187</sup> This result would not provide the needed assistance to the thousands of Americans who require emergency medical care. In fact, such a result would have the opposite effect by driving more marginally profitable hospitals out of business. A reduction in the number of hospitals would only aggravate an already critical problem for indigent persons and uninsured patients.

Indiana has interpreted the overlap between EMTALA and the state medical malpractice claims in a conflicting manner. Indiana has ruled that recovery under EMTALA is limited to Indiana's state limit on medical malpractice damages.<sup>188</sup> However, Indiana has also ruled that a claim under EMTALA does not incorporate Indiana's procedural requirements of submitting medical

183. Medical review panels are considered to be essential to malpractice cases because they help to encourage settlement of lawsuits, therefore decreasing court costs and congestion. Jean A. Macciaroli, *Medical Malpractice Screening Panels: Proposed Model Legislation to Cure Judicial Ills*, 58 GEO. L.J. 181 (1990). See generally 80 A.L.R.3d 583 (1992) (discussing medical malpractice screening panels).

184. 800 F. Supp. 1384 (E.D. Va. 1992). For a discussion of this case, see *supra* note 30 and accompanying text.

185. *Id.*

186. *Id.* at 1388-89. Prior to this decision, the United States District Court for the Western District of Virginia held that the maximum recovery under EMTALA for a pregnant woman who was not properly stabilized by a hospital was limited to Virginia's state medical malpractice cap on damages. *Lee v. Allegheny Regional Hosp.*, 778 F. Supp. 900, 904 (W.D. Va. 1991).

187. See *supra* note 30 and accompanying text.

188. *Reid v. Indianapolis Osteopathic Medical Hosp.*, 709 F. Supp. 853, 855 (S.D. Ind. 1989). The court emphasized that since EMTALA is silent on the issue of whether a cause of action for personal harm from patient dumping includes state caps on medical malpractice damages, and given the fact that Congress was aware of the state problems with excessive damage awards, the court held that the federal statute incorporates Indiana's medical malpractice cap on damages. *Id.* The court went on to say that EMTALA does not incorporate Indiana's procedural requirements in malpractice cases, and that on such procedural provisions EMTALA preempts state law. *Id.*

malpractice cases to a review panel.<sup>189</sup> It is difficult to see the distinction between a claim for medical malpractice and a claim for patient dumping. Even under the Indiana approach, which limits the damages to the state medical malpractice cap on damages, it appears that a plaintiff could recover up to the monetary cap under both a medical malpractice claim and a claim under EMTALA.

Steps should be taken to prevent the "personal harm"<sup>190</sup> claims brought under EMTALA from creating a federal medical malpractice claim. The federal courts should not be interpreting what a medical malpractice standard of care is while ruling on whether an appropriate medical screening<sup>191</sup> was given under EMTALA. The courts have been unable to accurately determine what standards are to apply in an EMTALA appropriate screening case, and how those standards differ from a medical malpractice standard.<sup>192</sup> Thus, additional legislation is needed in this area to provide courts, hospitals, physicians, and patients with clear guidelines as to the standard for bringing a patient dumping action for an inappropriate medical screening.

Indiana has recognized the inevitable overlap between EMTALA and state medical malpractice claims by determining that medical malpractice caps on damages apply to patient dumping claims.<sup>193</sup> This recognition should be taken further by the Indiana legislature, and it should be established that a claim for patient dumping is not a claim for medical malpractice, even though there is a clear overlap between the two causes of action. This overlap can be acknowledged without allowing two recoveries for medical malpractice, resulting in high awards against the medical facilities and ultimately possible closure of such facilities. Indiana should create its own patient dumping statute and provide that violation of that statute is negligence per se in a cause of action for medical malpractice. Medical facilities will still be deterred from patient dumping if a violation of the patient dumping law is found to be negligence per se for a medical malpractice claim. This new statute should be enacted at the state level so that its provisions can be properly monitored and enforced in a

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189. *Id.* See also *HCA Health Services of Indiana v. Gregory*, 596 N.E.2d 974 (Ind. Ct. App. 1992). The court held that the two year statute of limitations set forth in EMTALA was in direct conflict with the state procedural requirement, so the federal provision prevails. *Id.*

The medical review panel in Indiana consists of one attorney and three health care providers. IND. CODE ANN. § 16-9.5-9.3 (1992). The review panel gives its expert opinion on whether the defendant met the appropriate standards of care in the case. *Id.* § 16-9.5-9.7. Indiana requires that all cases against health care providers begin with an evaluation by the medical review panel, unless all of the parties involved waive the requirement in writing. *Id.* § 16-9.5-9.2.

190. 42 U.S.C.A. § 1395dd(d)(2)(A) (West 1992).

191. 42 U.S.C.A. § 1395dd(a) (West 1992).

192. See *supra* notes 171-72 and accompanying text.

193. See *supra* note 188 and accompanying text.

manner that the federal statutes have not been able to achieve.<sup>194</sup>

## V. THE STATE RESPONSE TO PATIENT DUMPING

### A. *The Common Law Approach*

The foundation case establishing that a hospital has a duty to render emergency care to a patient in an emergency condition is *Wilmington General Hospital v. Manlove*.<sup>195</sup> This ruling was based on an implied duty of care, premised on the fact that patients rely on hospitals to provide emergency care.<sup>196</sup> In contrast, the Supreme Court of Alabama has held that there is no duty on the part of a hospital to provide medical care unless a person is a patient of the hospital.<sup>197</sup> The court explained that when a hospital renders partial treatment and then transfers a patient, the hospital is not liable for any after-effects the patient experiences as long as the treatment the hospital provided did not create a condition that was extremely dangerous without further service.<sup>198</sup>

Even courts that are willing to establish a duty on the part of a hospital to render emergency care have held that there is no duty on the part of a physician

194. See *supra* notes 71-73 and accompanying text for a discussion of the Hill-Burton Act; see *supra* notes 160-68 and accompanying text for a discussion of EMTALA.

195. 174 A.2d 135 (Del. 1961). A detailed discussion of the development of the common law duty of care in emergencies is beyond the scope of this note, but see Karen H. Rothenberg, *Who Cares?; The Evolution of the Legal Duty to Provide Emergency Care*, 26 HOUS. L. REV. 21 (1989); Denise H. Field & Colleen M. Margiotta, Comment, *To Treat or Not to Treat: A Hospital's Duty to Provide Emergency Medical Care*, 15 U.C.D. L. REV. 1047 (1982); Michael A. Dowell, *Indigent Access to Hospital Emergency Room Services*, 18 CLEARINGHOUSE REV. 483 (1984).

196. *Wilmington Gen. Hosp. v. Manlove*, 174 A.2d 135, 139 (Del. 1961).

197. *Harper v. Baptist Medical Center-Princeton*, 341 So.2d 133, 134 (Ala. 1976). This case involved a patient who had a severed popliteal artery below his knee and was taken to the Baptist Medical Center for treatment. The Baptist emergency room provided treatment for four hours and then sent the patient to Mercy Hospital, a charitable hospital, because the patient did not have hospital insurance. *Id.* Mercy Hospital performed surgery on the patient's knee. The patient suffers from a permanent limp and constant pain. The evidence produced suggested that the patient's medical problems were a result of the initial accident he was involved in and not the medical treatment rendered. *Id.*

198. *Id.* The court's statement gives the hospital a considerable amount of leeway given the fact that the purpose of a hospital is to make sure that patients get treatment and recover, not to make sure they do not contribute to the injury the person is suffering from. A hospital should be required in emergency situations to render care that will prevent injury, and transfers should only be permissible when such an emergency situation exists if the transfer is being done for medical, not financial, reasons.

to render emergency care.<sup>199</sup> However, in *Hiser v. Randolph*,<sup>200</sup> the Arizona Supreme Court found that a doctor who worked for a hospital that had by-laws stating that patients would be given the best emergency room care, and that emergency care should be rendered as soon as possible after the patients arrival, was personally bound to ensure that such care was provided to patients.<sup>201</sup>

Arizona has been relatively aggressive in its attempt to deter hospitals from dumping patients.<sup>202</sup> The Arizona Supreme Court has held that public policy requires private and public hospitals to provide emergency care to all patients and that a patient may be transferred only if the transfer can be completed without the patient risking unreasonable harm to life or health.<sup>203</sup> Arizona Revised Statute section 11-297.01(C) states that a private hospital that renders care to an indigent patient may recover its costs for such services from the county.<sup>204</sup> The county is also financially responsible for any emergency care

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199. It has been stated: "The general rule is that a medical practitioner is free to contract for his services as he sees fit and in the absence of prior contractual obligations, he can refuse to treat a patient, even under emergency situations." *Findlay v. Board of Supervisors of Mohave County*, 230 P.2d 526 (Ariz. 1951); *Childs v. Weis*, 440 S.W.2d 104 (Tex. Civ. App. 1969). Section 5 of the American Medical Association Ethics Code requires physicians to render emergency service to the best of their ability. *Agnew v. Parks*, 343 P.2d 118 (Cal. Dist. Ct. App. 1959); *Hurley v. Eddingfield*, 59 N.E. 1058 (Ind. 1901).

200. 617 P.2d 774 (Ariz. Ct. App. 1980).

201. *Id.* at 277.

202. See Timothy G. Himes, Comment, "No Dumping Allowed": Has Arizona Solved the Patient Dumping Problem?, 21 ARIZ. ST. L.J. 1137 (1989).

203. *Thompson v. Sun City Hosp.*, 688 P.2d 605, 609 (Ariz. 1984). The court went on to state that a physician does not have a specific duty to render emergency care, and that any duty of care a physician owes is measured by what is usually done in the profession. *Id.* at 612.

204. The Arizona statute states:

The county shall be liable for payment of all costs retroactive to the inception of treatment incurred by a private hospital, a hospital operated by a university or health care provider licensed and arising from emergency treatment and medical care administered at such hospital for a patient qualified for such care and treatment under the provisions of this article on compliance with subsection C and in either of the following circumstances:

1. When the emergent condition of the patient is such that it is deemed medically inadvisable to transport the patient from the private hospital or hospital operated by a university for further treatment.
2. When the county does not move the patient from the private hospital or hospital operated by a university within twelve hours after being notified by the private hospital or hospital operated by a university authorities of the location and condition of the patient.

ARIZ. REV. STAT. ANN. § 11-297.01(B) (West Supp. 1992).

an ambulance service provides for an indigent patient.<sup>205</sup> In addition to provisions for emergency care, the Arizona Supreme Court has held that a private hospital may not cease giving medical care to an indigent patient who is seriously ill even when there is no longer an emergency condition.<sup>206</sup>

### B. State Statutory Response

Twenty-one states have responded to the patient dumping problem through legislation.<sup>207</sup> Many of the state statutes are brief and do not define the term

205. The statute providing for emergency services from ambulances states:

When an indigent emergency medical patient is received by an emergency receiving facility from an ambulance with necessary medical equipment and supplies to provide emergency medical services the county shall be liable to the ambulance service for the cost of transporting the patient and to the facility for the reasonable costs of all medical services rendered to such indigent by the facility until such patient is transferred by the county to the nearest county hospital, or some other facility designated by the county.

ARIZ. REV. STAT. ANN. § 41-1837(A) (West 1991).

206. *St. Joseph's Hosp. & Medical Center v. Maricopa County*, 688 P.2d 986, 990 (Ariz. 1984). This case involved an indigent patient who was in an automobile accident and received emergency medical care at a private hospital. After the emergency medical condition was stabilized, the patient remained at the private hospital and received nursing care. *Id.* The county hospital refused to accept the patient as a transfer. The court found that the private hospital had a duty to continue treatment of the patient, but that the county was responsible for paying for the costs of the treatments at the private hospital. *Id.*

207. The state statutes provide as follows:

California, CAL. HEALTH & SAFETY CODE § 1317 (1991) states:

Emergency services and care should be provided to any person requesting the services or care, or for whom services or care is requested, for any condition in which the person is in danger of loss of life, or serious injury or illness, at any health facility licensed under this chapter that maintains an emergency department.

*Id.* § 1317(a). The Code further provides that emergency services should not be based on race, ethnicity, religion, national origin, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services. *Id.* § 1317(b). The code also defines emergency condition:

[E]mergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- (1) Placing the patient's health in serious jeopardy.
- (2) Serious impairment to bodily functions.
- (3) Serious dysfunction of any bodily organ or part.
- (4) Active labor means a labor at a time in which either of the following would occur:

- (1) There is inadequate time to effect safe transfer to another hospital prior to delivery.
- (2) A transfer may pose a threat to the health and safety of the patient or the unborn child.

*Id.* § 1317(b). Specific procedures to be followed if a patient is transferred are also provided. *Id.* § 1317.2. A violation of the code may result in civil fines of up to \$25,000, but the maximum

cumulative fine under the code and the federal statute, EMTALA, is \$30,000. *Id.* § 1317.6.

Georgia, GA. CODE ANN. § 31-8-42 (1991), requires any hospital with an emergency service to provide care to a woman in active labor if the woman is a resident of the state, and such services are usually and customarily provided within the medical facility. *Id.* Provisions are also established that if a transfer of a woman in active labor is made the facility must contact the receiving facility, arrange suitable transportation, and send information on the patient's condition and history to the receiving hospital. *Id.* § 31-8-42(2). The statute allows for a cause of action for damages or other appropriate relief if a hospital violates the statute. *Id.* § 31-8-45 (1991). A fine of \$500 per violation may also be imposed. *Id.* § 31-8-46.

Hawaii, HAW. REV. STAT. § 321-232 (Michie 1993), states:

No ambulance services, or any other medical services available from or under the authority of this chapter shall be denied to any person on the basis of the ability of the person to pay therefor or because of the lack of prepaid health care coverage or proof of such ability or coverage.

*Id.* The Code does not provide for any cause of action if medical care is denied based on inability to pay for the services.

Illinois, ILL. REV. STAT. Ch. 111 1/2, para. 86 (1991), provides:

Every hospital required to be licensed by the Department of Public Health . . . which provides general medical and surgical hospital services shall provide [such services] to any applicant who applies for the same in case of injury or acute medical condition where the same is liable to cause death or severe injury or serious illness.

*Id.* A violation of the statute may result in a fine not to exceed \$10,000 per violation. *Id.* at par. 87.

Kentucky, KY. REV. STAT. ANN. § 216B.400 (Baldwin 1991), provides: "Where a person has been determined to be in need of emergency care by any person with admitting authority, no such person shall be denied admission by reason only of his inability to pay for such services to be rendered by the hospital." *Id.* § 216B.400(1). A violation of this statute may be punished by a fine of not less than \$100 and not more than \$500. *Id.* § 216B.990. It is important to note that the statute imposes a subjective definition of a medical emergency and that no relief is provided if an admitting authority claims there was no emergency. Further, a fine of \$100 to \$500 is likely to be more appealing to a hospital than rendering care to an indigent patient.

Louisiana, LA. REV. STAT. § 40:2113.4 (1992), requires a hospital which receives aid from the state to provide emergency room services to all persons that reside in the territorial area of the hospital regardless of whether the person is covered by insurance. *Id.* § 40:2113.4(A). Services shall not be withheld based on race, religion, national ancestry, age, sex, physical condition, or economic status. *Id.* An emergency condition is defined as one which places the person in imminent danger of death or permanent disability, or in the case of rape. *Id.* § 40:2113.4(B). The penalty that is imposed if this statute is violated is that the facility will no longer receive referrals from the Department of Health and Human Resources. *Id.* § 40:2113.4(A).

Massachusetts, MASS. ANN. LAWS ch. 111, § 70E (Law. Co-op. 1993), provides:

Every patient or resident of a facility shall have the right to prompt life saving treatment in an emergency situation without discrimination on account of economic status or source of payment and without delaying treatment for purposes of prior discussion of the source of payment unless such delay can be imposed without material risk to his health . . . .

*Id.* The statute provides that any person whose rights are violated may bring a civil action. *Id.* This statute makes no attempt to define what an emergency situation is, and the allowance of delay in services is provided in such a vague statement that it is likely that hospitals will continue to delay treatment, or refuse to render it, based on an individual's economic status.

Michigan, MICH. COMP. LAWS § 333.20921 (1993), requires ambulance services to provide life support without prior inquiry of ability to pay. *Id.* § 333.20921(1)(e). This statute applies only

in the narrow amount of cases that deal with patients being dumped from ambulance services and provides no assistance to patients who are dumped from emergency rooms which is where the heart of the patient dumping problem lies. In addition, this statute provides for no specific remedy or penalty if there is a violation.

Missouri, MO. REV. STAT. § 205.989(1) (1992), provides, "No person because of inability to pay shall be denied the services of a community health center, mental health clinic, or other public facility or not for profit corporation in which a county or participating counties have established services or provided funds." *Id.* The main weakness of this statute is that many patient dumping cases take place from private hospitals, not public facilities, and this statute does nothing to alleviate this problem. In addition, no remedy is given for a violation.

Nevada, NEV. REV. STAT. ANN. § 439B.410 (Michie 1991), provides that hospitals have a duty to provide emergency services and care, and that they may not refuse to treat a patient in need of emergency care, or transfer a patient unless the patient is medically fit for the transfer, the receiving facility has accepted the transfer, the patient has had an explanation for the transfer and has consented to it. *Id.* A hospital that violates this provision causing another hospital to have to render care may recover three times the charges of the care plus reasonable attorneys fees from the hospital that wrongfully discharged the patient. *Id.* The key terms in the statute such as "emergency services and care" and "medically fit" are defined in the statute. *Id.* A violation of the statute may result in criminal penalties or denial, revocation, or suspension of the hospital's license, and criminal penalties, disciplinary penalties, or licensure denial against the physician. *Id.*

New Hampshire, N.H. REV. STAT. ANN. § 151:21 (1992), states, "The patient shall be transferred or discharged only for medical reasons, for his welfare or that of other patients, if the facility ceases to operate, or for nonpayment for the patient's stay except as prohibited by the Social Security Act." *Id.* The statute further provides, "The patient shall not be denied appropriate care on the basis of race, religion, color, national origin, sex, age, disability, marital status, sexual preference, or source of payment." *Id.* The statute provides for no remedy if there is a violation.

New York, N.Y. PUB. HEALTH LAW 2805-b (Consol. 1993), provides:

Every general hospital shall admit any person who is in need of immediate hospitalization with all convenient speed and shall not before admission question the patient or any member of his or her family concerning insurance, credit or payment of charges, provided, however, that the patient or a member of his or her family shall agree to supply such information promptly after the patient's admission.

*Id.* The statute also states that transfers shall be made:

[O]nly when acceptance of an additional critical patient may endanger the life of that patient or the life of another patient. A request for the diversion of other emergency patients shall only be made when all appropriate beds are filled and shall be withdrawn as soon as a bed is available.

*Id.*

Oregon, OR. REV. STAT. § 441.094 (1991), provides that a hospital licensed by the Health Division may not deny care to a person that the admitting physician diagnoses as being in need of emergency medical services, and that the emergency medical services customarily provided by the hospital cannot be denied to a person because they are unable to establish that they have the ability to pay for the services. *Id.* § 441.094(1). The statute also defines emergency medical services as those which must be provided to sustain life, prevent serious permanent disfigurement or loss or impairment of the function of a bodily member or organ, or provision of care to a woman in active labor. *Id.* § 441.094(4). One problem with this statute is that whether a person has an emergency medical condition is completely within the discretion of the admitting physician. Another problem is that no provision for a remedy or cause of action is given in the statute.

Pennsylvania, PA. STAT. ANN. tit. 35 § 449.8 (1992), provides:

The general assembly finds that every person in this Commonwealth should receive timely and appropriate health care services from any provider operating in this

Commonwealth; that, as a continuing condition of licensure, each provider should offer and provide medically necessary, lifesaving and emergency health care services to every person in this Commonwealth, regardless of financial status or ability to pay; and that health care facilities may transfer patients only in instances where the facility lacks the staff or facilities to properly render definitive treatment.

*Id.* This statute is weak in that it does not attempt to define any of the key terms it is using such as what emergency medical care consists of specifically. In addition, no remedy is given and there is no apparent means to enforce the statute.

Rhode Island, R.I. GEN. LAWS § 23-17-26 (1991) states:

Every health care facility that has an emergency medical care unit shall provide to every person prompt life saving medical care treatment in an emergency, and a sexual assault examination for victims of sexual assault without discrimination on account of economic status or source of payment, and without delaying treatment for the purpose of a prior discussion of the source of payment unless the delay can be imposed without material risk to the health of the person.

*Id.* The enforcement procedures available are to report a violation to the director of the state department of health and the director will do what they deem to be appropriate.

South Carolina, S.C. CODE ANN. § 44-7-260 (Law Co-op 1991), provides:

No person, regardless of his ability to pay or county of residence, may be denied emergency care if a member of the admitting hospital's medical staff, or in the case of a transfer, a member of the accepting hospital's medical staff determines that the person is in need of emergency care. Emergency care means treatment which is usually and customarily available at the respective hospital and that must be provided immediately to sustain a person's life, to prevent serious impairment or disfigurement, or loss or impairment of the function of a bodily member or organ, or to provide for the care of a woman in active labor if the hospital is so equipped and, if the hospital is not so equipped to provide necessary treatment to allow the woman to travel to a more appropriate facility without undue risk of serious harm.

*Id.* The statute's enforcement provisions include that a hospital's license status may be affected if there is a violation, and also that a civil penalty of up to \$10,000 may be imposed against the hospital. *Id.* § 44-7-260(E). Again, under this statute whether an emergency medical condition exists is for the hospital's staff to determine. *Id.*

Texas, TEX. HEALTH & SAFETY CODE ANN. § 311.022 (1993), provides:

No officer, employee or member of the hospital medical staff of a general hospital shall deny emergency medical services available at the hospital to a person diagnosed by a licensed physician as requiring emergency services because the person is unable to establish his ability to pay for the services or because of race, religion, or national ancestry. In addition, the person needing the services may not be subjected to arbitrary, capricious, or unreasonable discrimination based upon age, sex, physical condition or economic status.

*Id.* The statute goes on to define emergency services, and states that criminal penalties of a class B misdemeanor to a third degree felony can be imposed for violation of the statute. *Id.*

Utah, UTAH CODE ANN. § 26-8-8 (1992), provides, "Emergency medical services shall be provided to all patients in need of such services to sustain life or prevent loss of life without regard to race, sex, color, creed, or prior inquiry as to ability to pay." *Id.* The statute makes no attempt to define what emergency medical services consist of and no provisions are made for any cause of action that will be taken if a violation occurs.

Vermont, VT. STAT. ANN. tit. 18 § 1852(8) (1992), lists rights that a patient has and includes the right of the patient to receive complete information and explanation regarding a transfer, and also provides that the facility the patient is being transferred to must accept the patient. *Id.* This legislation does not appear to have any impact on the requirement that medical facilities render care

“emergency medical condition.”<sup>208</sup> States that do define emergency medical condition often leave the determination of that condition to the physician or hospital.<sup>209</sup> The use of a subjective test may weaken the purpose of the patient dumping legislation because all the medical facility has to do to avoid liability is classify indigent patients they do not wish to treat as being in a non-emergency medical condition. An objective test for an emergency medical condition would be more effective, allowing a judge and jury to determine if a medical emergency in fact existed and whether the hospital failed to treat the medical condition properly under state law.

State patient dumping laws are also weakened by the fact that ten of the twenty-one states that have patient dumping statutes provide no cause of action

to a patient since all that is required is an explanation to the patient and approval by the accepting hospital. In addition, the patient is given no course of action if their rights are violated.

Wisconsin, WIS. STAT. § 146.301 (1989-1990), states:

No hospital providing emergency services may refuse emergency treatment to any sick or injured person. In addition, no hospital providing emergency services may delay emergency treatment to a sick or injured person until credit checks have been made if the delay is likely to cause increased medical complications, permanent disability or death.

*Id.* The remedy for a violation is a fine of \$1000 for each offense. *Id.* This statute appears to give a broad definition of emergency services. Most state statutes have included some provision defining the seriousness of the injury or illness, thereby narrowing the care the hospital is required to provide.

Wyoming, WYO. STAT. § 35-2-115 (1992) provides:

Emergency service and care shall be provided, at the regularly established charges of the hospital, to any person requesting such services or care, or for whom such services or care is requested, for any condition in which the person is in danger of loss of life, or serious injury or illness, at any hospital licensed in the state of Wyoming that maintains and operates emergency services to the public when such hospital has appropriate facilities and qualified personnel available to provide such services of care.

*Id.* The statute goes on to say that if the hospital decides they have inadequate personnel, or that they do not have the proper equipment or facilities, than the hospital and its employees shall not be liable for failure to render emergency care. *Id.* Under this statute all the hospital has to do if they do not wish to treat an indigent patient is to say that they did not have the proper facilities or personnel on staff to render treatment. It appears from the statute if the hospital established this as the reason they did not even attempt to render emergency care, then there can be no relief obtained by a patient who is dumped.

208. GA. CODE ANN. § 31-8-42 (1991), HAW. REV. STAT. § 321-232 (Michie 1993), and KY. REV. STAT. ANN. § 216B.400 (Baldwin 1993) make no attempt to define the crucial term medical emergency condition. MASS. ANN. LAWS ch. 111, § 70E (Law. Co-op. 1993), MICH. COMP. LAWS ANN. § 333.20921 (1993), PA. STAT. ANN. tit. 35 § 449.8 (1992), R.I. GEN. LAWS § 23-17-26 (1991), and UTAH CODE ANN. § 26-8-8 (1992) provide that emergency medical services are required to be rendered if there is a need to prevent a loss of life. These definitions seem to apply in a narrow band of cases, and don't appear to cover someone who is suffering from a serious illness, or a woman who is in active labor.

209. KY. REV. STAT. ANN. § 216B.400 (Baldwin 1993), OR. REV. STAT. § 441.094 (1991), S.C. CODE ANN. § 44-7-260 (1990).

or penalty if emergency medical services are refused.<sup>210</sup> Eleven of the states that have patient dumping statutes have remedies available for a violation, but six of those statutes have weak remedies that are unlikely to deter a facility from dumping a patient.<sup>211</sup> For example, the fine in Kentucky for patient dumping is no less than \$100 and no more than \$500.<sup>212</sup> Similarly, Georgia provides for a \$500 fine.<sup>213</sup> Rhode Island's patient dumping statute has a vague provision that permits the health director of the State Department to receive a report of violations and permits the director to take whatever action is deemed to be necessary.<sup>214</sup> The remote threat that a violation would be reported and investigated is not an effective way to prevent medical facilities from dumping indigent patients.

Given the fact that indigent patients who are denied emergency medical care will probably not have the necessary funds to bring a private cause of action, the state patient dumping laws should include a provision that attorneys fees will be paid if the plaintiff successfully shows improper denial of care. It is also important that states create aggressive enforcement procedures that include a comprehensive notification process so that indigent patients will be aware of their rights.<sup>215</sup>

Louisiana's patient dumping statute states that if a medical facility violates the provisions, the Department of Health and Human Resources will not make any more client referrals to that facility.<sup>216</sup> Again, in light of the great expense a facility faces in rendering treatment to an indigent person with no ready means to pay for the services, anti-dumping sanctions such as these will not deter medical facilities from dumping patients.

California, Nevada, and Texas have developed aggressive remedies to solve the patient dumping problem. The California statute provides a fine against the

210. HAW. REV. STAT. § 321-232 (Michie 1993), MICH. COMP. LAWS § 333.20921 (1993), MO. REV. STAT. § 205.989(1) (1992), N.H. REV. STAT. ANN. § 151:21 (1992), N.Y. PUB. HEALTH LAW 2805-b (Consol. 1993), OR. REV. STAT. § 441.094 (1991), PA. STAT. ANN. tit. 35 § 449.8 (1992), UTAH CODE ANN. § 26-8-8 (1992), VT. STAT. ANN. tit. 18 § 1852(8) (1992), WYO. STAT. § 35-2-115 (1992).

211. GA. CODE ANN. § 31-8-46 (1991), KY. REV. STAT. ANN. § 216B.990(3) (Baldwin 1993), LA. REV. STAT. § 40:2113.4 (1992), MASS. ANN. LAWS ch. 111, § 70E (Law. Co-op. 1993), R.I. GEN. LAWS § 23-17-26 (1991), WIS. STAT. § 146.301 (1989-1990).

212. KY. REV. STAT. ANN. § 216B.990(3) (Baldwin 1993).

213. GA. CODE ANN. § 31-8-46 (1991).

214. R.I. GEN. LAWS 23-17-26(b) (1991).

215. EQUAL ACCESS, *supra* note 2, at 11. "No matter how strong the statute, it is useless without enforcement. . . . It can only serve as a deterrent if it is enforced. A law sitting quietly on the books will not serve as an obstacle to violations." *Id.*

216. LA. REV. STAT. § 40:2113.4(A) (1992).

hospital of \$25,000 per violation.<sup>217</sup> In addition, a physician may be fined up to \$5000 for patient dumping.<sup>218</sup> If medical facilities are made aware of this kind of fine, and the fines are actually enforced against facilities that commit a violation, it is very likely that the number of patients dumped each year will decrease. In addition to a high fine, California also outlines the procedure to be followed whenever a patient is transferred, including notification to the transferring hospital and acceptance of the patient by the transferring hospital.<sup>219</sup> The California statute also requires hospitals licensed by the state to adopt regulations that include a policy that prohibits discrimination in the provision of emergency care.<sup>220</sup>

Additionally, the California statute requires that hospitals explain to patients the reason for a transfer and the person's right to emergency care.<sup>221</sup> The statute also mandates that all hospitals must post notice in the emergency rooms informing patients of their rights to emergency care.<sup>222</sup> If a hospital fails to adopt the policies required by the statute, the hospital is given a notice that their regulations do not meet the state law, and then, if after sixty days the hospital has not changed its regulations, a fine of \$1000 per day is imposed.<sup>223</sup>

Nevada and Texas impose criminal sanctions against a medical facility that dumps patients.<sup>224</sup> Under the Nevada statute, criminal penalties are available against both the hospital and the physician, and the license of both the hospital and physician may also be affected.<sup>225</sup> Nevada also provides that when a hospital violates the statute and refuses to render care to an indigent patient, the

217. CAL. HEALTH & SAFETY CODE § 1317.6(a) (1991). In addition, the statute lists factors that are to be considered in determining the amount of the fine to be imposed:

- (1) Whether the violation was knowing or unintentional.
- (2) Whether the violation resulted or was reasonably likely to result in a medical hazard to the patient.
- (3) The frequency or gravity of the violation.
- (4) Other civil fines that have been imposed under Section 1395 of Title 42, EMTALA.

*Id.*

218. *Id.* § 1317.6(c). California is one of the few states that imposes a fine against physicians under its patient dumping statutes.

219. *Id.* § 1317.2.

220. *Id.* § 1317.3(b). Further, the statute provides that physicians who are on call at the hospital cannot discriminate against patients when they are rendering emergency care based on the patient's race, ethnicity, religion, citizenship, age, sex, preexisting medical condition, physical or mental handicap, insurance status, economic status, ability to pay for medical services. *Id.* § 1317.3(c).

221. *Id.* § 1317.3(d).

222. *Id.* § 1317.3(d).

223. *Id.* § 1317.3(e).

224. NEV. REV. STAT. ANN. § 439B.410(6-7) (Michie 1991), TEX. HEALTH & SAFETY CODE ANN. § 311.022(2 d-e) (1993).

225. NEV. REV. STAT. ANN. § 439B.410(6-7) (Michie 1991).

hospital that does provide the care may recover three times the charges of the care and reasonable attorneys fees from the hospital that refused to provide the required care.<sup>226</sup> However, in reality many facilities will not bring a cause of action against one another due to professional camaraderie.<sup>227</sup>

The Texas statute provides that no officer, employee, or member of a hospital medical staff shall deny emergency services to a patient based on the fact that the patient is not able to pay for the services.<sup>228</sup> If this statute is violated, criminal penalties from a class B misdemeanor to a third degree felony charge may be imposed.<sup>229</sup> The fear of having a criminal penalty imposed is a powerful deterrent that may prevent hospitals from dumping patients. The federal statute EMTALA originally contained criminal sanctions.<sup>230</sup> However, the House of Representatives revised the legislation and deleted the criminal sanctions.<sup>231</sup> The House explained that a criminal negligence standard would penalize medical facilities with criminal sanctions for actions that may have been a simple mistake, and found that such a provision was too harsh.<sup>232</sup> In addition, there were constitutional problems with a criminal penalty under the void-for-vagueness provision since key terms, such as appropriate medical screening, are difficult to define precisely.<sup>233</sup>

Indiana has not taken any steps through the common law or through statutory enactments to alleviate the problem of patient dumping. In light of the failure of the federal regulations with the Hill-Burton Act<sup>234</sup> and EMTALA,<sup>235</sup> Indiana should adopt its own patient dumping laws to provide emergency medical care to all people, whether they are indigent or wealthy. A state patient dumping statute can be enforced more effectively than a national federal standard. As a matter of public policy, Indiana should adopt a statute

226. *Id.* § 439B.410(3).

227. EQUAL ACCESS, *supra* note 2, at 18. The House Report explained that receiving hospitals may be reluctant to report violations of patient dumping because of the need for good relationships between medical facilities, and that facilities do not want to "squeal on one another." *Id.* Therefore, there must be alternative objective procedures to ensure that patients are not dumped since relying on medical facilities to turn one another in does not appear to be the answer to the problem.

228. TEX. HEALTH & SAFETY CODE ANN. § 311.022 (1993).

229. *Id.*

230. H.R. REP. NO. 241, 99th Cong., 2d Sess. 5 (1986), *reprinted in* 1986 U.S.C.C.A.N. 726-730.

231. *Id.*

232. *Id.* at 729.

233. *Id.* The House explained that what constitutes an appropriate medical screening means different things to different people, and that a criminal negligence standard would be too vague and would cause people to guess at what is appropriate medical care under the statute. *Id.*

234. *See supra* notes 71-73 and accompanying text.

235. *See supra* notes 160-68 and accompanying text.

that provides for emergency medical services to be rendered to all patients who require such care. In addition, Indiana should include comprehensive enforcement provisions.

## VI. PROPOSED RESOLUTION

This Note proposes that Indiana adopt a patient dumping statute that is more vigorous in its application and enforcement procedures than previous federal attempts to regulate the problem. Furthermore, Indiana should directly address the problem of the overlap between medical malpractice and patient dumping claims.<sup>236</sup> The following proposed statute creates remedies that will encourage plaintiffs to properly bring medical malpractice claims in Indiana state court, not as attached claims to EMTALA.

### PROPOSED MODEL STATUTE FOR INDIANA REQUIREMENT OF EMERGENCY CARE AND ADEQUATE TRANSFERS OF PATIENTS

#### *A. Purpose*

The purpose of this statute is to deter the dumping of patients and assure that all people are provided with emergency medical health care regardless of their ability to pay. In addition, this statute is designed to prevent discrimination in treatment based on physical or mental condition, sex, race, national origin, age, or handicap. The statute is designed to deter patient dumping, not to compensate individuals for harm they have suffered due to improper medical treatment. Therefore, this statute sets its own limits on civil monetary amounts that may be recovered, and recovery is not measured by Indiana medical malpractice caps on damages. In addition, claims under this statute are not required to be submitted to the Indiana medical review panel.

#### *B. Legal Obligations to Provide Emergency Care*

(1) All hospitals, medical facilities, physicians, medical staff, and ambulance services and employees are required to render care to any person who is in an emergency medical condition without regard to a person's ability to pay, physical or medical condition, sex, race, national origin, age, or handicap. If any hospital, medical facility, physician, medical staff, or ambulance service or employee transfers a patient who is suffering from a medical emergency condition, and the transfer is likely to result in any kind of deterioration of the person's physical or medical condition, such a medical facility will be sanctioned

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236. See *supra* notes 171-94 and accompanying text.

under this statute for patient dumping. When a patient is transferred while in a medical emergency condition, it will be presumed under this statute that such a transfer was an improper action by the transferring medical facility, and the burden will be on that facility to show by a preponderance of the evidence that the transfer was done for legitimate medical reasons that were in the patient's best interest.

(2) All medical facilities and ambulance services are required to provide all persons to whom treatment is rendered notice of the legal obligation such facility has to provide emergency medical services. On an individual basis such notice is to be provided in written or oral form and before treatment is rendered unless that is impossible given the condition of the patient. In addition, each facility is required to post notice in the emergency room, the waiting area for the emergency room, the billing office, and any office that deals with financial aid or payments, of its obligation to provide emergency care. A violation of this provision will result in a civil monetary fine of up to \$25,000 per violation.

### *C. Definitions*

(1) Any individual who is refused emergency medical treatment may bring a cause of action under this statute, and there is no requirement of an allegation or proof of indigency to recover damages.

(2) A medical emergency condition exists when any patient suffers from an illness or serious threat of harm to his or her body or organs, which may result in death, disfigurement, extended health problems, serious pain, or damage to bodily organs. In addition, any woman who has gone into labor is deemed to be in an emergency medical condition, and if labor has begun it is presumed that the woman should not be transferred unless the medical facility can show that there was sufficient time to transfer the woman without endangering the woman or the unborn child. Victims of child abuse or sexual assault who come to a medical facility will also be considered to be in an emergency medical condition. Whether an emergency medical condition existed as required under this statute will be for the Judge or Jury to determine with the assistance of the relevant records and experts in the field of Emergency Medicine.

(3) To recover under this statute there is no requirement that the patient arrive in the emergency room of the facility. If the facility operates clinics or tertiary operator systems, the facility may be held liable for patient dumping that occurs in those units as well as the main facility.

(4) A medical facility that refuses to accept a transfer of a patient in an emergency medical condition will also be liable for patient dumping under this

statute. Such actions constitute reverse patient dumping and are subject to the same penalties under this statute.

#### *D. Remedies*

(1) A violation of this statute may result in a civil action being brought by the individual who was refused treatment or the State Department of Health. Recovery is limited to a maximum of \$150,000 per violation. Two-thirds of the monetary amount recovered will go to the individual who brings the suit and the other one third will be placed in a State fund with the purpose of providing health care for the indigent. If the action is brought by the state Department of Health, the entire amount of the award will be placed in the fund for health care for the indigent.

(2) A violation of this statute constitutes negligence per se in a cause of action for medical malpractice for improper medical treatment. This presumption can be rebutted by the physician or hospital if they can show, by a preponderance of the evidence, that the care rendered met the standard of reasonableness in the profession.

(3) Any medical facility or physician with more than two violations under this statute will be ineligible to receive payment from the indigent health care fund for services they render to indigent patients.

(4) Any plaintiff who successfully shows that he or she was denied emergency medical care in violation of this statute is entitled to reasonable attorneys fees as part of the costs.

#### *E. Comments*

As a commentary to the proposed statute, the following examples are intended to show how previous cases would yield a different result under the proposed statute.

The case of *Powers v. Arlington Hospital*<sup>237</sup> would have a different outcome under this new statute. Under the proposed legislation, Powers, who brought a patient dumping claim under EMTALA and recovered four million dollars in damages, would recover only a maximum of \$100,000 under the proposed statute. Powers could then use the violation of EMTALA as negligence per se in a medical malpractice claim against the hospital. When Powers brought her medical malpractice claim all of the state safeguards against

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237. 800 F. Supp. 1384 (E.D. Va. 1992). See *supra* note 30 and accompanying text.

malpractice claims, such as caps on damages and the requirement of submission to a medical review board, would be in force.

In addition, the Indiana case of *Reid v. Indianapolis Osteopathic Medical Hospital*<sup>238</sup> would be resolved differently under this proposed legislation. There would be no need to classify patient dumping claims as limited by state medical malpractice claims, making the federal claim a quasi-federal medical malpractice cause of action. Instead, the maximum amount of fines under the patient dumping statute is set at \$150,000. If the plaintiff chooses to bring a cause of action for medical malpractice under the state law, all of the procedural safeguards such as malpractice caps and medical review boards will monitor the case.

Moreover, this statute resolves the problem of requiring patients to allege that they arrived at the hospital emergency room as a requirement for a patient dumping claim.<sup>239</sup> The ruling in *Johnson v. University Hospital*<sup>240</sup> would be reversed under this statute. A medical facility that operates an emergency service outside the physical premises of its main facility can be held liable for patient dumping under this statute from either its main facility or from ancillary services the facility offers.

#### *F. Analysis of Proposed Legislation*

The proposed legislation is intended to avoid previous problems of patient dumping regulations at both the federal and state level. First, the statute clarifies that any individual may bring a cause of action for patient dumping. There is no requirement that indigency or improper motive on the part of the medical facility must be proven to state a cause of action for patient dumping.

In addition, a plaintiff is not required to show that they arrived in the emergency room to state a cause of action. If arrival at the emergency room is a factor that must be proven for a patient dumping claim, hospitals would be well-advised to make such arrival a restricted process. Facilities could establish tertiary operators to direct away patients they do not wish to treat. Moreover, hospitals could keep patients in the waiting room or other area of the hospital if they thought the patients would be likely candidates to be dumped.

The amount of recovery available under the proposed statute is limited so that hospitals will not be burdened to the extent they must close down. Hospital closures would only add to the problem of indigent access to health care.

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238. 709 F. Supp. 853 (S.D. Ind. 1989). See *supra* note 188 and accompanying text.

239. See *supra* notes 119-50 and accompanying text.

240. 982 F.2d 230 (7th Cir. 1991). See *supra* notes 142-50 and accompanying text.

Legislation must be created with cost containment problems of the hospitals clearly in mind. Further, a penalty of \$25,000 is imposed for failure to comply with the notice provisions. This is a high monetary penalty because of the importance of notifying indigent patients of their rights to health care.

#### VII. CONCLUSION

The federal responses to the patient dumping problem under EMTALA and the Hill-Burton Act have failed to prevent patient dumping. State statutes have had some success in eliminating the problem. The state level, where physician licensing and regulations of hospitals are conducted, is the proper place to address the patient dumping problem. In order to prevent excessive fines against hospitals, resulting in closure of the facilities, Indiana should adopt legislation clearly stating that a claim for patient dumping is not an alternative route to collect more money for what is essentially a state medical malpractice claim. It is important to separate the cause of action for patient dumping from the cause of action for medical malpractice.

Patient dumping should be closely monitored, and patients must be made aware of their rights under the patient dumping laws. Aggressive enforcement of the proposed Indiana legislation should lead to a decrease in the number of patients who are dumped each year. This will result in all Americans receiving the medical emergency treatment they require.

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